Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Edwin M. Becker ,2011 9:30 PM November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore Examiner 4b. City, Town, or Location of Death 3411 N. Trail Way Parkville Social Security Number If Under 1 Year I If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 215-10-1865 95 Months Days Feb. 18, 1916 Yrs. Maryland Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9109 H.Lincolnshire 21234 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. by 1 Never Married 2 Married 2 🗌 No Maryland 21215-0036 1 ☐ Yes 2 →No Specify. white "natural", 3 Widowed 4 Divorced Specify Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hyglene. ant: If item 27 is marked other than ury or other traumatic event, the Me Mail Room Superintendent Elementary/Seconday (0-12) 12 College (1-4 or 5+) Baltimore News American Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည John Becker Constance Schwartz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
9109 H. Lincolnshire Court-Parkville, Maryland 21234 Gertrude Becker-spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Nov.17,2011 permit. Page Department of Important: If any injury or Baltimore, Maryland Oak Lawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility

1. A.C. Funeral Chapel and Cremation Services

21234 ansha 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ mal disease or condition resulting in death) Jan Medical Due to (or as a conseq I nce of) Examiner araumy ope Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): signed by the attending physician and be detached for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed meumonia that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed?

1 Yes 2 No 2 XNo funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Daughter's Other: မ 1 🗌 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec Director: After this d in by the funeral d 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical 29a. Certifier 1 Secretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 17 per fh g921 11-16-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year tm Gr 7:582 M 2011 Medical 2 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/AExaminer 4b. City, Town, or Location of Death Baltimere Kaven CLC . Age (In yrs. last birthday) 6.5 If Under 1 Year I If Linder 24 Hrs Sex 1XXM 2 □ F 9. Birthplace (State or Foreign **Funeral** 8. Date of Birth Hours OCT 24, Year) 946 Country Director Yrs Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at filed within 72 hours after death with the Maryland al Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Baltimore 1 Yes 2X No 10f. Zip Code 21206 10e. Street and Number 6700 Beech Ave 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian Black, White, etc. à 1 Never Married 2 Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: Completed 3 XWidowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)
Self Employed 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 1 2 t h Hardware Store College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Bauer 18. Mother's Name (First, Middle, Maiden Surname) Ambrose Robert Basuer, Sr. Mary Anna Jenkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Wentworth/ 6700 Beech Ave. Balto., MD 21206 Stepson 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State Garrison Forest 11/30/11 Owings Mills, 4 ☐ Donation 5 ☐ Other (Specify) 21. Si mature di Funeral Service Licensee 27 Name and Address of Eacility Rewerly Blits, mantie 42 £ 48 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Paucreatiris Physician/ disease or condition resulting in death) K71524 Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that in the cause (Disease) Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Yunknown Completed peen a Were autopsy findings available prior to completion of cause of 24a. Was an cate has by page 2 s autopsy perform death? certificate 1 ☐ Yes 2 ☐ No Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 📝 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 🗆 Yes 2 🗀 No 1 Natural injury within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tife of certifier 29d. Date signed (Month, Day, Year) mu 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 31. Date filed (Month State Registrar

Å DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Claude Leigh Brooke Dayo, Physician/ November 20°11 2:00 P M Medical 4a. Facility Name (if not institution, give street and number) 9006 Town and Coutry Blvd 4b. City, Town of Location of Death ity **Examiner** 4c. County of Death Howard . Age (In yrs. last birthday) Birthplace (State or Foreign Country)
 DC Social Security Number 214-36-2066 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1**X** M 2 □ F Days Hours 0872871939 Director Usual Residence of Deceden 10a. State MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Howard Ellicott City 1 X Yes 2 No 10e. Street and Number Town and Country Blvd. 10f. Zip 60f043 10g. Citizen of What Country? Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: Specify: White Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary (Seconday (0-12) College (1-4 or 5+) Food Warehouseman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Claude Brooke Marian Camp 19a. Informant's Name/Relationship (Type, Print)
Susan M. Kidwell / 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
204 Lindsay Dell, Glen Burnie, MD 21061 Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place Atlantic crematory 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2XXCremation 3 🗀 Removal from State 11/12/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensed Orota, Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardiac Arrythmia Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** 20 Yrs. Coronary Artery Disease Sequentially list conditions Day to for as a nonecqueries of cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events and burial-trar Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the bur completed filled in by the funeral director, page 2 should be detached for use as the bur. P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3XX Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Certificate: To 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗡 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Pay, Year) November 11, 2011 D 17821

641

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 16

2011

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type Frint) Rd., Suite 204, Ellictott City, MD Warren Ross, MD, 4801 Dorsey Halli Rd., Suite 204, Ellictott City, MD

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

cian/ dical	Registrar 1. Decedent's Name (First, Middle, La Paul Eugene	,	Cenific	cate of L)Eall	2. Date of De	Reg. No. 2	Year	3650 3. Time of Death 10:25a
niner	4a. Facility Name (if not institution, giv. 501 Annabel A		4b.		Location of Death		4c. Count	ty of Death	
al or		Sex 7. Age (In yrs. last	t birthday) If U Mor Yrs.	Inder 1 Year oths Days	If Under 24 Hrs. Hours Min.	8. Date of Bir 0 57 2 0		9. Birthp Count	olace (State or Forestry) CT
Director			Town or Location					1	0d. Inside City Lim
Funeral D		ve	10	f. Zip Code 2122	5		10g. Citizen of	What Coun	try?
þ	1 ☐ Never Married 2 🄀 Married	12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No If Yes, Give 1970 — Year or Dates.	If Yes,	ecedent of Hi specify Cuba es 2 X No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Bla	ce - Americ ack, White, e y: Whit	etc.
Completed	15. Decedent's (Specify only highest g	Education rade completed) College (1-4 or 5+) 2yrs	life. DO NO	Usual Occup f work done of T use retired)	during most of work	ing	16b. Kind of E		dustry
To Be	17. Father's Name (First, Middle, Last) Medore J. Brea				18. Mother's Nam	e (First, Middle, Lla C.		ne)	
	19a. Informant's Name/Relationship (Dawn Schaefer-	-Breault wife	501 Aı	nnabel	and Number or Run	altimo	re MD	21225	5
41	20a. Method of Disposition 1 □ Burial 2X□ Cremation 3 [4 □ Donation 5 □ Other (Spec	Removal from State At	ce of Disposition netery, crematory lantic	crem	11/	Date 1 1 1	20c. Location	Burni	le MD
ouce	21. Signature of Funeral Service Licer	All			ss of Facility Sir LenPA 70				
dical Examiner	disease or condition resulting in death) Squadility list coudility if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as a consequer Due to (or as a consequer c. Due to (or as a consequer d	USE nce of):		ung	<i></i>			
<u> </u>	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnanc 1 ☐ Live Birth 2 ☐ Fetal of	death 3 - Ecto	pic pregnanc	у		1	ate of delive	ery Day Year
hysician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ath 5 Othe	er (specify)					
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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene For State Registrar 36505 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Dav Month Year CARL WINSTON COLLINSBEY. 7-25 PM 02 201 Medical 11 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospital Center BALTIMORE N/AHarbor 6. Sex Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 ★ M 2 🗆 F Days Hours Min. 47 **Director** Maryland <u> 212 90 1612</u> 1963 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director Baltimore N/AMaryland 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21225 2706 Giles Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Specify: Black 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Year or Dates other than "natu 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) David Edwards Co. Upholsterer permit. Page 1 and 2 should be filed with Department of Health and Mental Hygien Important: If item 27 is marked other tay injury or other traumatic event, the once. 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) English Cooper Mamie Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2706 Giles Road Baltimore, Maryland 21225 Annette Kent/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) M Burial 2 Cremation 3 Removal from State Lansdowne, Maryland Zion Cemetery 11/9/11 4 Donation 5 Other (Specify) Mt. 22. Name and Address of Facility Chatman 5240 Reisterstown RD Signature of Funeral Service Licensee -Harris FuneralHome Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Shock Septic Medical resulting in death) Due to (or as a consequence of) Examiner IVer CIRPHOSIS unknown Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury and that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ hed by the atter in the past 12 months? Day Year Ves 2 No 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ End stape Kidney disease: 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has After this certificate 1 ☐ Yes 2 ☐ No the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ☑ No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 \square Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESOOI Caga 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harbor Hospital Center Baltimore MD State

DHMH 17 Rev 7/2009

Registrar

Please Type of Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death YOPM Day Month Year **Physician** 0 12 ona November 2011 /Medical Facility Name (If not institution, give street and number, 4c. County of Death 4b. City. Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center Baltimore **Baltimore** If Under 1 Year | If Under 24 Hrs. | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 171-24-2775 Director 89 Jan. 25,1922 Pennsylvania Usual Residence of Decedent with the Maryland 10a, State 10h County 10c. City, Town or Location 10d Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at one. 1 ☐ Yes 2 TXNo Director MD Baltimore Timonium 10e. Street and Number 10f. Zip-Code 10g, Citizen of What Country? 21093 USA Funeral 681 Budleigh Circle Was Decedent Ever in U.S Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔯 No Specify Specify: White à 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Giuseppe Corda Dorata Nicolai ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nick Corda (Son) 681 Budleigh Circle, Timonium, MD 21093 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11-17-2011 Restwood Cemetery 4 Domation 5 Other (Specify) Hinton, WV 22. Name and Address of Facility Pivont Funeral Service, Inc. 21. Signature of Juneral Service Lice lan 100 Park Avenue, Hinton, WV Lum Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Resultatory Due to (o' as a consequence **Physician** disease or condition resulting in death) failure /Medical Examiner Intracerebral Hemorrhage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 1 weeks Examine Due to for as a consequence on: death certificate be executed typertension Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ 1 ☐ Yes 2 No 3 Probably 4 Unknown certificate has been sig director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 新文 Division of Vital F 2 Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \square Nursing Home 5 \square Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 2 6 Other (Specify) After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 🗌 Yes 2 🗌 No 2 Accident after death Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide filled in 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the within 2 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 000 November 12,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) emmon M onica 4940 Eastern Avenue, Baltimore, MD, 21224 31. Date filed (Mooth Day, Year) NOV 1 6 2011 32 Aegistrar's Signature State Registrar barka

DHMH 17 Rev 1/2001 11595

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) November 13,2011 Physician/ 11:55 P M Wilma Darlene Christ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Parkville Baltimore 8606 Richmond Avenue If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) NOV . 8 , 1950 220-56-7628 Maryland 1 🗆 M 2 🔀 Director 61 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State must be notified at Director 1 Yes X No Parkville MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 20 10e. Street and Number 23a Funeral 8606 Richmond Avenue 21234 items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12 Was Decedent Ever in U.S. Examiner Armed Forces? Black, White, etc. 1 Never Married 2 Married "natural", or þ Specifywhite Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) than, Elementary/Secondary (0-12) College (1-4 or 5+) At Home Homemaker 12 should be filed with alth and Mental Hygien 27 is marked other the Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 0 Florence Eilene Barnes William Barnett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9024 Hines Road-Parkville, Maryland 21234 ge 1 and 2 slit of Health a Hope Hemphill-daughter 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place)
Oaklawn Cemetery Nov. 18,2011 Baltimore, Maryland Signature of Funeral Service Licenses Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chncen Physician/ LUNG disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underhin, Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ been signed by the atter should be detached for in the past 12 months? Month Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director. After this certificate has I completely filled in by the funeral director. Dage 2.8 autopsy performed Yes 2 death? 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 \(\sum \) Nursing Home 5 \(\mathbb{P}\) Residence 6 \(\sum \) Other (Specify) 1 ☐ Yes 2 ➡No ER/Outpatient 3 DOA မ 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 27 Manner of Death Certificate: 1 Natural 5 Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 15 2011 Name and address of person who completed cause of death (Item 23a) (Type, Print) Balto, mo 21224 Fastor ave

DHMH 17 Rev 06-2011

State

Registrar

6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36508 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Novembe Physician/ 2:42AM Mary Anna Cook 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner City, Town, or Location of Death 4c. County of Death tizens Nre de Social Security Number 9. Birthplace (State or Foreign Country) Maryland Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🔀 F Dec. 15, Hours Year 933 Director 220-32-3183 ural", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Churchville Maryland Harford 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21028 3005 Rolling Green Drive death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2**X** No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 No Specify "natural", 3 X Widowed 4 ☐ Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 11 Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental H Martha Rebecca Ayres George B. Sills 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21028 permit. Page 1 and 2 sh.
Department of Health ar
Important: If item 27 is
any injury or other trans 3005 Rolling Green Drive, Churchville, Maryland Tammy Watters / Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State St. Mary's Cemetery 4 Donation 5 Other (Specify) 11/16/2011 Abingdon, Maryland 21. Signature of Funeral Service License McComas Funeral Home, P.A. 22. Name and Address of Facility 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of). sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. sate has been signed page 2 should be de 23e. Did tobacco use contribute to the cause of death? by Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2★No 24a. Was an autopsy Yes 25. Was case referred to medical B 26. Place of Death (Check only one) examiner? 은 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending within 24 hours after death To the Funeral Director: A Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 the only one Certifying Nurse Practioner: In the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Date filed (Month) Day, Year State

Registrar

NOV 1 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 7:30 P.M John Irwin Cole, Sr. 7, 2011 November 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Glen Burnie Anne Arundel North Arundel Health & Rehab. 7. Age (In yrs. last birthday) If Under Months If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) 08/19/1950 5. Social Security Number 6. Sex 1 XM 2 ☐ F 212 56 2912 61 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 Yes 2 No Glen Burnie Anne Arundel Maryland 10g. Citizen of What Country? 10f Zip Code 10e. Street and Number U.S. 21061 103 98 Mary Lane Apt. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: White If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4or 5+) A & P Tea Company Senior Computer Analyst 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Margaret A. Bennett Robert S. Cole 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Glen Burnie, Maryland 21061 98 Mary Lane Apt. 103 Gail Cole / Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 11/12/2011 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Baltimore Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signatur of Funeral Service/G Baltimore, Maryland 21225 4001 Ritchie Highway 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) S_quentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of 10K8 Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy Month Day in the past 12 months? 1 Yes 2 No 9 Unknown 5 Other (specify) 4 Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ColeTIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown DSOSIASIS 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 ☐ Yes 🙎 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Magner of Death 1 Natural 5 Pending 2 □ No

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Be Completed by Funeral

2

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours effer death with the Marylan Department of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f show any Injury or other traumatic event, Ita Medical Examinat must be ricitified at once.

Baltimore, Maryland 21215-0036

Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit Physician/Medical à Completed To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director. Be Certification: To

Division of Vital Records, P.O. Box 68760

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

a

investigation

6 Could not be determined

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a. Certifier

RHANDELWAL, MD.

delivel

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1 Yes

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 11/09/2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Physicial 313 HOSPITAL DR. GLEN BURNE, Md. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D29873

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Nov 8, 2011 **Donald Henry Carew** 2:00 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Baltimore** Catonsville 717 Maiden Choice Lane ST 411 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days (Month, Day, Year) Sep 25, 1934 Country) Months Hours Min. MD 216-30-7423 **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗆 Yes 2 No Catonsville MD **Baltimore** 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 21228 U.S.A. 717 Maiden Choice Lane ST 411 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗙 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) **Project Manager** Contracting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Walter Carew Louise Kaiser 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Maiden Choice Lane Apt. ST411 Catonsville, MD 21228 Carol Carew Wife other 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State Nov 12, 2011 Elkridge, Maryland Meadowridge Memorial Park, 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Hospital or Attending Physician: The law equires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Pregnant at time of death Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? To Be Completed by 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, is 26. Place of Death (Check only one) examiner? 2 🔼 No ☐ Nursing Home 5 🗗 Residence 6 ☐ Other (Specify 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a To the Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Registrar

DHMH 17 Rev 7/2009

KOLODRU

31. Date filed (Month, Day, Year)

(Item 23a) (Type, Print)

18

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State	State of Marylar				/lental Hyg	iene		
			Registrar 1. Decedent's Name (First, Middle, La	oth	Cer	tificate of L	Death		eg. No. 20	1,365	
	Physici		CVI VIT A	LEIBOWITZ	(CUMMINS		2. Date of Deat	ER ^{Da} 13 20 1	3. Time of De 07:25	
	Medi V Exami		4a. Facility Name (if not institution, give				r Location of Death	NOVELIBI	4c. County of D		- TA IVI
	t .		7 SLADE AVENUE,	#411		PIKESV	ILLE		BALTI		
	Funeral Director		5. Social Security Number 6. S		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9.	Birthplace (State or Fo	oreign
		4	Usual Residence of Decedent	□м 2 🗓 ғ	98 Yrs.			06/08/		NY	
	/land f sho	ţċ	10a. State 10b. County	10c. Cit	y, Town or Loc	ation			<u> </u>	10d. Inside City L	imits
	he Maryland or 28a-f show notified at	Direc	MD BALTIN	ORE P	IKESVII					1 🗆 Yes 2	X No
	ith the	ral	10e. Street and Number	11.1.1		10f. Zip Code		1	0g. Citizen of What	,	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	7 SLADE AVENUE,	12. Was Decedent Ever in U.S	S. 13. V	21208 /as Decedent of H	ispanic Origin? (Spe	cifv Yes or No-	1/ Bace - A	USA American Indian,	
20	fter de , or it amine		1 Never Married 2 Married	Armed Forces? 1 Yes 2 No		Yes, specify Cuba ☐ Yes 2 No	ispanic Origin? (Spe in, Mexican, Puerto	Rican, etc.)		/hite, etc.	
3	ours a tural'	Completed by	3 🕅 Widowed 4 🗆 Divorced	If Yes, Give Year or Dates.					Specify: W	HITE	
9200-91212	72 h	Jgm	(Specify only highest gr	ade completed)	(Give k	ent's Usual Occup ind of work done o NOT use retired)	ation duning most of worki	ing	16b. Kind of Busine	ess/Industry	
.17	withir giene er tha		Elementary/Secondary (0-12)	College (1-4 or 5+)	,,,o. De	MERCH	ANT		DRA	PERIES	
בים	I be filed within fental Hygiene rked other th tic event, the	To Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M	aiden Surname)		
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Σ	2 shouth and the shou		19a. Informant's Name/Relationship (7) JERRY LEIBOWITZ/				and Number or Rura				
ē,	of Health and Ments of Health and Ments fitem 27 is marker rother traumatic e		20a. Method of Disposition	20b. P	lace of Dispos	ition (Name of	1 ,		20c. Location - City		
Ē	Page ment c ant: If ury or		1 🖾 Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	Removal from State	RLINGT HTZIIK	atory or other plac ON CEMET I AMUNO	ËRY 11/14	/2011	BALTIMO	RE MD	
baltimore,	permit. Page 1 Department of Important: If i any injury or once,		21. Signature of Funedal Service Licent				ss of Facility SOL				
	₽□ = 60	Н	230 Part 1 Enter the diseases or some	uge						, MD 21208	
3	Obveniejen/	Н	23a. Part 1. Enter the disease, or com shock, or heart failure. List only o Immediate Cause (Final	ne rause on each line.						Approximate Interval Between Onset and Deat	
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5	aw rec as bee 2 sho	Completed						24a. Was an		autopsy findings availa	
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	sician: The certificate rector, pag	<u> </u>	25. Was case referred to medical examiner?	Hospital:			ce of Death (Check		92,10)	103 2 110	
5	r this eral di	5: To	1 Yes 2 No 27. Manner of Death	1 Inpatient 2 E	R/Outpatient		4 U Nursing Hor		ce 6 Other (Sp	ecify)	
	ath. r: Afte	Certificate:	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	28c. Injury work?		8d. Describe how	injury occurred		
	irecto	ertif	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hon	ne, farm, stree					Rural Route Number,	
	ours af			building, etc. (Specify)				City or Town,			()
1	or en cospinal or Autenting Prysician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Oricon 2 in Medical Examil	cian: To the best of my knowle er: On the basis of examination	and/or investio	ation, in my opinior	n death occurred at t	he time date and	nlace and due to th	a cause(s) and manner	stated.
4	within To the		29b. Signature and title of certifier	Practitioner: To the best of my	/ knowledge, d	eath occurred at the 29c. License	e time, date and plac	e, and due to the	cause(s) and manne	r as stated.	
			(Value	Soll	MU		1543			(13, 201	1
	151		30. Name and address of person who co	ompleted cause of death (Item 2	23a) (Type, Prir	nt)					_
	State		31. Date filed (Month, Day, Year)			C 10951	Ocad S Di	rive c	mines	nuls, aud:	2(11
	Registra		NOV 1 6 2011 /	32. Registrar's Signary	arke						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 0755 A.M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death City, Town, or Location of Death Examiner Bathmore aven bene 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Numbe 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Min. 1 M 2 5 F 46 Director 062-60-8885 1965 New_ Usual Residence of Decedent 28a-f show 10d. Inside City Limits of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location with the Maryland Director 1 🗌 Yes 2 🔀 No Windsor Mill Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21244 USA Funeral 6915 Rockfield Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event the Madicin 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11 Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify. Black 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11th grade Unemployed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eddo Davis Linda Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6915 Rockfield Road Windsor Mill, Maryland Linda Davis/ Mother Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 11/21/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Greenmount Cemetery 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of Funeral Service Licensee 5240 Reisterstown Road Baltimore, MD 21215 23a. Por 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a cons a ence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of): as the burial-transit and that initiated events Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: for use a 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death detached g Unknown n signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one)

Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has director, in by the funeral

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Certificate:

Medical

31. Date filed (Month, Day, Year)

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examiner? Other: 2 No Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1. Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State)

29a. Certifier (Check only one)	Certifying Physician: To the best of my knowledge, death oc Medical Examiner: On the basis of examination and/or investig Certifying Nurse Practioner: To the best of my knowledge, de	ation, in my opinion, death occurred at th	ne time, date and place, and due to the cause(s) and manner stated
29b. Signature a	ng title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

address of person who completed cause of death (Item 23a) (Type, Print) ariam

32. Registrar's Signature

State Registrar

completed filled

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Davon Larry DiGGS

11-08306

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Physicia	n/	teglistrar 1. Decedent's Name (First, Middle,Last) Davon Larry Diggs		Date of Death Month D November 5		3. Time of Death 2111 hrs			
rodical Examin }	G		Town, or Location of Death	November 5	4c. County of Death	21111113			
	Н	Johns Hopkins Hospital Bayview Medical Center Baltin			N/A				
Funeral Director		212-29-1778 _{1\(\big M\) 2\(\big F\) 21 Yrs. Month}	der 1 Year If Under 24Hrs. hs Days Hours Min.	8. Date of Birth(MM/DD/YYYY) 9. Birth Foreign Cou	nplace (State or ntM)D			
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
and f show	٥	MD N/A Baltimore			0777 - 1 1 Miles + 1 October 1	1X Yes 2 No			
death with the Maryland or items 23s or 28s-f show must be notified at once.	Dire	1702 Latrobe Rd 21	213	Ū	Citizen of What Coun				
ifter death with or items 2	by Funeral	1 Never Married 2 Married Armed Forces? If Yes, speci	ent of Hispanic Origin? (Speify Cuban, Mexican, Puerto F Mexican, Puerto F Mo s <i>pecify:</i>		14. Race - Americ White, etc. AITICA Specify: AME	n			
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Itant: Witem 27 is marked other than "natural", or items 23s or 28s-fahe or other traumatie event, the Medical Examiner must be notified at once	Be Completed	College (1-4 or 5+) during most of wo	l Occupation (Give kind of working life. DO NOT use retine)river		6b. Kind of Business/Ir Taxi	ndustry			
21215-0036 Juld be filed within 7 I Mental Hygiene, marked other than ic event, the Medica		17. Father's Name (First, Middle, Last) William Diggs	18.Mother's Name Wanda B	everly					
MD 27 d 2 should lth and Me n 27 is ma numatic co		19a. Informant's Name/Relationship (Type, Print) Wanda Beverly/Mother 19b. Mailing Addres One Coop	s (Street and Number or R Derative Dr	.#214,E	Balt.,MD	21213			
Baltimore, MD 212 permit Pages I and 2 should be Department of Health and Ment Important: Witem 27 is markinjury or other traumatic even		20a. Method of Disposition 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specific	11/		Balt., MD	Fown, State			
Baltil permit. Departm Imports injury o		21. Signature of Funeral Trivice Licen 22. Name and 5126	Address of FacilityHar Belair Rd,						
Physician ,/Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode failure. List only one cause on each line. Immediate Cause (Final disease a, Gunshot Wounds (2) to the Chest and Le		respiratory arres	t, shock, or heart	Approximate Interval Between Onset and Death			
Æxaminer		Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause							
nted & /	ledical Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): d.							
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Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and applietly filled in by the funeral director, page 2 should be detached for use as the burial - transit	2	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 5 Other (Spa		ncy	23d. Date of delivery Month D	day Year			
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ords, P w requires the seen signs of should be d	Completed by			24a. Was ar	24b. Were au	topsy findings available ompletion of cause of			
Recol The law icate has	Comp	Deformed? death? 1 ✓ Yes 2 No 1 ✓ Y							
Vital Rec yrician: The l his certificate l director, page	å	25. Was case referred to medical examiner? 1 Ves 2 No Hospital: 1 Inpatient 2 FR/Outpatient 3	26.Place of Death (Check of DOA Other Nursing		esidence 6 Other	:			
on of V ading Phy th. r: After th	ion: To	1 ✓ Yes 2 No III III III III III III III III III	28c. Injury at Work? 1 Yes 2 ✔ No	28d. Describe ho Subject was s	w injury occurred shot				
Divisic pital or Atte ours after dea eral Directo	24a. Was an autopsy performed? 1								
To the Hospita within 24 hours To the Funeral completely filler		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the control one) 2 Medical Examiner: On the basis of examination and/or investigation, in n	ne time, date and place, and ny opinion, death occurred a	due to the cause at the time, date a	(s) and manner as state nd place, and due to th	ed e cause(s)			
To the within To the comple	Medical	and manner stated.	9c. License number		29d. Date signed (Mo	nth, Day, Year)			
γ		Hany Jouthall, MD	O.C.M.E.		November 6, 201	11			
4		30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 900 W. B	saltimore Street, Baltin	more, MD 21	223				
St	ate	31 Parefiled (Month) Dey Year) 32. Registrar's Sonetyte							

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1:00 Gregory Allan Dodd Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Anne Arundel Glen Burnie If Under 1 Year If Under 24 Hrs. Social Security Numbe Age (In vrs. last birthday 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, pril 10 1 x M 2 D F Hours Min. Mary land 216-17-8072 1978 Director April Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits 10c. City. Town or Location death with the Maryland Examiner must be notified at **Funeral Director** 1 Yes 2 X No MD Pasadena Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 23a U.S.A. 7694 Briar Lane Pasadena, Maryland 21122 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. ò ģ 1 A Never Married 2 Married Maryland 21215-0036 be filed within 72 hours after If Yes, Give Year or Dates 1 ☐ Yes 2 ☐xNo Specify. Specify: White "natural" 3 Divorced Completed and Mental Hygiene.

is marked other than "natul
aumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Barbara Jean Kagle John Thomas Dodd, Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 7694 Briar Lane Pasadena, Maryland 21122 John Thomas Dodd, Jr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 11/15/2011 21. Signature of Funeral Savice Licenses 22. Name and Address of Facility McCully Polyniak Funeral Home P.A. 3204 Mountain Road, Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physicians disease or condition Medical resulting in death) Due to (or as a cor sequ. ce of): Examiner Sequentially list conditions, Due to lor as a consequence of cause. Enter Underlying Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Other (specify) Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown signed by the a d be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 **X** No 3 Probably 4 Unknown 1 🗌 Yes should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 2 No ျှ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this . Date of injury (Month, Day, Year) funeral 27. Manner of Deat 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred After Natural Accider 5 Pending injury Investigation Accident 24 hours after deat Funeral Director; Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ģ 4 Homicide determined filled in ! Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completed fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and th (Item 23a) (Type, Print) Name and address of State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Physician/ 2011 7:55A Anna Margaret Doty November Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Middle River Ivy Hall Nursing Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** 219-18-1307 Director 1 M 2XX 87 Feb. 05, 1924 Maryland or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location Director Paltimore 1 Yes 2XXNo Maryland Phoenix 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 21131 4022 Cloverland Drive 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. "natural", or i edical Examin 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. 1 Yes If Yes, Give 2 No White 1 Yes 2 X No Specify: 3X Widowed 4 □ Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natun traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home 12 Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Jennie K. May Anton Horky 19a. Informant's Name/Relationship (Type, Print) Important: If item 27 is any injury or other traus Janet L. Scheiner (Daughter) 4022 Cloverland Drive Phoenix, Maryland 21131 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Dulancy Valley Memorial November 19, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State injury or Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fineral Service Licensee

22. Name and Address of Facility
Evans Funeral Chapel & Cremation
8800 Harford Road Parkville, Me
23a. Part 1. Enjectified disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or freat failure. List only one cause on each line. Name and Address of Facility Evans Funeral Chapel & Cremation Services—Parkville 8800 Harford Road Parkville, Maryland 21234 Approximate Interval Between Onset and Death Immediate Cause (Final Ptrysician/ disease or condition resulting in death) Medical consequence of): Due to (or as Examiner Sequentially list conditions, Examiner cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tra Due to (or as a consequence of) Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 phy IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 2 No 2 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred 1 X Natural 5 \square Pending injury 2 🗌 No e Funeral Director: A Funeral Director: A pletely filled in by the fi Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

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completely 1 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 7.0 11/11 002213 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Sebastion Did 3023 Easte Easter.

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State Registrar 31. Date filed (Mor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ DREWanz 05:57 AM Νου 15 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Iniversity of Manyland Medical Cente Baltomore Social Security Numb If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth (Month, Day, Year) Director 217-34-4767 1 💢 M 2 🗆 F 72 08/31/1939 MD Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 2 should be filed within 72 hours after death with the Maryland than Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director Anne Arundel Crownsville 1 ☐ Yes 2 🎇 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 1027 Park Road 21032 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) College Professor 5+ Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ Drewanz, II Henry Mary Muth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st. Department of Health ar Important: If item 27 is Mrs. Joyce E. Drewanz / Wife 1027 Park Road Crownsville, MD 21032 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1
Burial 2
Cremation 3
Removal from State injury o 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 11/17/2011 Glen Burnie, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1 2nd Avenue SW Glen Burnie, MD any Singleton Funeral & Cremation Services, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ herniation Cerebra disease or condition Medical resulting in death) 30 hours Examiner STROKE and cytoboxic edema Section tially list condition, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine burial-transi resulting in death) Last Physician/Medical as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by hupertension, diabetes, congestor hear failure, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an BPH perform completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital ျ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred or Attending 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, overfly country at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier NOV 15 2011 tutta m. D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South Greene St. Baltmare, MO Z120/ 101

State Registrar DHMH 17 Rev 06-2011

Box (

Records,

of Vital

Division

TARA GUTTAMA

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 11, 4:30 A. M John Robert Denbow Sr. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Baltimore Augsburg Lutheran Home 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea Aug. 29 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Country) Maryland Year) 13 M 2 | F Director 213-18-7308 90 Aug. Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Gwynn Oak 1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 21207 6825 Campfield Road Apt. 11 M-1 be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) d Mental Hygiene. marked other than College (1-4 or 5+) Elementary/Seconday (0-12) 12 Grocery Store Meat Department Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Isabel (nmn) Smithson Elwood (nmn) Denbow . Page 1 and 2 should b tment of Health and Mer tant: If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 21207 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6825 Campfield Road Apt. 11 M-1, Gwynn Oak, MD Anna R. Denbow / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 s
Department of IImportant: If ite
any injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Air Memorial Gdn. 11-15-11 Bel Air, Maryland 22 Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, M 21. Signature of Funeral Service Cicens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 1000 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on Examir cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 - Residence 6 - Other (Specify) 2 No Hospital 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DCA ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 037573 1105. pleted cause of death (Item 23a) (Type, Print) XIV 30. Name and address of person who co

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36518 For State Registrar Certificate of Death s Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month : 15 PM Medical Name (if not institution, give street and number)
MCGurik Drive Examiner or Location of Death . County of Death Anne Arunde l Glen Burnie If Under 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 215-40-7091 7. Age (In vrs. last birthday) 1 Year If Under 24 Hrs. **Funeral** Months 68 06/20/1943 **Director** 1 XM 2 F MD 28a-f show 10a 10c. City, Town or Location notified at 10d. Inside City Limits Director Anne Arundel MD Glen Burnie 1 Yes 2X No 10f. Zip Code 21060 10g. Citizen of What Country? ō 10e, Street and Number must be 23a 2 McGurik Drive Funeral items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian or than "natural", or ite Black, White, etc. þ 1 Never Married > Married Yes 2 XNo Baltimore, Maryland 21215-0036 hours after If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced Specify: White Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mentat Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Plumber Plumbing permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Worley Dix Mary Shanahan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

2 McGurik Drive, Glen Burnie, MD 21060 19a. Informant's Name/Relationship (Type, Print) Patricia Dix/ Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Chesapaeke Crematory 11/14/2011 Bletsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last -trar Due to (or as a consequence of) burial nding physician Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death the a ed by tl detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed is should be det 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an , page 2 autopsy performe 1 Yes 2 No Division of Vital in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 21 10 Other: 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending Accident 1 Yes 2 No M Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours aft

To the Funeral Dir

completely filled in Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and titl 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) of deat 30. Name and address

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11-08166 Kimberly Dubois Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

4a. Facility Name (if not institution, give street and number) Upper Chesapeake Medical Center Function	imberly Dubois	State of Maryland / Department of Health and Mental Hygiene 1- For State Registrar Certificate of Death Reg. No. 201	1 3651
Director Director Commonwealth Commonwealth	Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last) Kimberly DuBois 2. Date of Death Month Day Year October 31, 2011	
178 - 60 - 2908 2	è		
To Surger and Number 100 Capts 100 Cap		078-60-2908 36 Yrs. Months Days Hours Min. 08/10/1975 Foreign Co.	thplace (State or in untry) N Y
Married State 1		10a. State 10b. County 10c. City, Town or Location Edgewood	1 X Yes 2 No
21. Scamber of Function Service Licenses. Denote Marshall 22. Name and address of Facility. Permaticion Services 21203 23. Facility Continues and Probable and Continues and Address of Proposition Services and	21215-0036 ould be filed within 72 hours after death with the Na Mental Hygiene. s marked other than "natural", or items 23a or ic event, the Medical Examiner must be notified. To Be Completed by Furneral Dir	11. Marital Status 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1	can Indian, Black, White Industry are , Zip Code) MD 21040 Town, State
Second Column C	Palti Physician Physician Examiner	21. Signature of Funeral Service Licensee Darota Marshall 22. Name and Address of Facility Maryland Cremation Services 2120 23a: Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Uisease or injury that initiated	Approximate Interval Between Onset and
29b. Signature and title of certifier 29c. License number 29d. Date signed (<i>Montin</i> , Day, Year) O.C.M.E. November 2, 2011	O, be executivisician and ourial - tra	FFEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1	the cause of death? pably 4 Unknown
30. Name and address of person who completed cause of death (Item 23a)	Division of Vital Recol To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 st Medical Certification: To Be Compl	25. Was case referred to medical examiner? 1	rugs ral Route Number, City hristopher ed. le cause(s)
· · · · · · · · · · · · · · · · · · ·	ok pend	30. Name and address of person who completed cause of death (Item 23a)	11

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36520 2011 State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death 2011 7:04 Pm Physician/ No∜ëmber DeVincentis Michael L. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A Baltimore 5713 Charlestowne Drive Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 96 **Director** 219-03-6839 1 🔀 M 2 🗆 F October 4 1915 Maryland Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10b. County 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director 1 X Yes 2 □ No Baltimore N/A Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral U.S.A. items 23a 21212 5713 Charlestowne Drive 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Medical Examiner Black, White, etc. Armed Forces? 1 ▼ Yes 2 No ō 1 Never Married 2 X Married 2 Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify It Yes, Give Year or Dates:1942-1946 Specify: White "natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Secondary (0-12) Medicine the Surgeon Department of Health and Mental Hygin Important: If Item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Petracelli Angelina ၉ Louis DeVincentiis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Md. 21212 Rosemary DeVincentis / Wife 5713 Charlestowne Drive 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other pl 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) JulaneyValleyMem.Gdns 11/17/2011 Timonium, Maryland 22. Name and Address of FacilityRuck Towson Funeral Home, Inc. Signature of Fu 1050 York Road Towson, md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dysphania 40476 disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine Due to lorge a consequence on if any, leading to immediate cause. Enter Underlying Cause (Disease or injury for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live Birth 2 Fetal death Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown

been signed by the s should be detached page 2 funeral director. Certificate: To this within 24 hours after death.

To the Funeral Director: Af completely filled in by the fu

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 100 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? 1 ☐ Yes 2 ☐ No 5 Pending injury 1 Natural Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Svite 4105, Touson MD21204



00061199

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jasan Black uni), 670(N Cha Charles ST.

State Registrar

Medical

only one)

29b. Signature and title of certification

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ EDMONDS Medical 4a. Facility Name (if not institution, give street and number)
Seasons Hospice 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 5. Social Security Number 212-30-2299 **Funeral** Days April 124, 1915 County C 96 Director 1 🗆 M 2 🔀 F 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. Count 10c. City, Town or Location Director MD N/ABaltimore 1X Yes 2 ☐ No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 2432 Hollins Ferry Road 21230 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify Blask Completed by Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) Hospital Dietary 7. Father's Name (First, Middle, Last) Asa Coleman 18. Mother's Name (First, Middle, Maiden Surname) Calena Williams 19a. Informant's Name/Relationship (Type, Print)
Shirley Bell/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2432 Hollins Ferry Rd Balto., MD 21230 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 11/22/11 Baltimore, MD Loudon Pk Cem 4 Donation 5 Other (Specify) 22. Name and Address of Facility Beverly D. Cromartie F/S 2700 Edmondson Ave., Balto., MD 21223 Approximate Interval Between Onset and Death 23a. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Yes 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perfor Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: Ay No 1 🗌 Yes ER/Outpatient 3 DOA ျှ 5 Residence 1 Inpatient 2 I 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pending 1 Yes 2 🗌 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Medical 29a. Certifier Notertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Nampand address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

erry Richard Eyler	State of Maryland A	Department of Certificate of	f Health and Mental H f Death	ygiene Reg. 1	No. 201	1 3652
Physician/	Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death 0155 hrs
ledical Examine	Jerry Richard Eyler 4a. Facility Name (if not institution, give street and number)	1.	4b. City, Town, or Location of Deat	Month Da November 2	2011 4c. County of Death	01001118
	9404 Chatteroy Place		Montgomery Village		Montgomery	
Funeral Director	5. Social Security Number 6. Sex 7. Agr 1 M 2 F	e (In yrs. last birthday) 58 Yrs	If Under 1 Year If Under 24Hr Months Days Hours Mir		MM/DD/YYYY) 9. Birth 1953 Foreign Cou	1
any	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Locati	on			10d. Inside City Limits
*	MD Montgomery	Montgome	ry Village			1 Yes 2 No
the Maryland or 28a-f show tified at once.	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Count	ry?
ith the 33a or notifie	9404 Chatteroy Place 11. Marital Status 12. Was Decedent	Fire in H.C. I 12 Wa	20886 s Decedent of Hispanic Origin? (S	posific Vos or No	USA 14. Race - Americ	an Indian Black
or items 23 must be no Funeral	1 Never Married 2 Married Armed Forces?		es, specify Cuban, Mexican, Puerto		White, etc.	
s after d	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2 No specify:		Specify: Whi	
"natur Exam	15. Decedent's Education (Specify only highest grade com Elementary/Secondary (0-12) College (1-4 or 5	during m	t's Usual Occupation (Give kind of ost of working life. DO NOT use rel		b. Kind of Business/In	dustry
5-0036 ed within 72 hour 13 yige ene within 72 hour other than "natu the Medical Exau Completed	12yrs		Wholesaler		Auto In	dustry
21215-0036 und be filed within 7 Mental Hygiene. marked other than c event, the Medica fo Be Comple	17. Father's Name (First, Middle, Last)			e (First, Middle, Mai	den Surname)	
2121 could be fil d Mental H s marked tic event,	Unk 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing	Jean E Address (Street and Number or	The second secon	r, City or Town, State,	Zip Code)
MD at 2 sho alth and m 27 is numati	Connie Soriano Auth Ac	,	8 Goshen Oaks		hersburg	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once To Be Completed by Funeral Director	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from Sta	ate crematory or oth			Glen Burn	
Itim iit. Pag irrment ortant:	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Atlantic	lame and Address of Facility Si			
Dept.	Thomas EACh	Th	omasAllenPA 7	090 Rido	ge Rd Han	over MD
Physician	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.		ne mode of dying, such as cardiac	or respiratory arrest,	shock, or heart	Approximate Interval Between Onset and Death
Examiner	Immediate Cause (Final disease or condition resulting in death) a. Intra-oral Gunsh Due to (or as a conse					Deali
	Sequentially list conditions, b.					
Examiner	if any, leading to immediate Due to (or as a consecuence. Enter Underlying Cause (Disease or injury that initiated					
Ex assistance of the second of	events resulting in death) Last Due to (or as a conse	equence of):				
O, e be execut ysician and burial - tra	UNPENDED AMENDED					_
	IF FEMALE: 23c. If yes, outcom 23b. Was decedent pregnant in the		tal death 3 Ectopic pregn	ancv	23d. Date of delivery Month Di	ay Year
Box 6876(c death certificate the attending phy, ed for use as the b hysician/Me	past 12 months?	time a set also atta	her (Specify)			,
b. Box 6876 the death certificat the death certificat oy the attending phyched for use as the Physician/M		n but not resulting in the u	Inderlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
i, P.O. signed by I be detack				1 Yes	2 No 3 Proba	ably 4 Unknown
Division of Vital Records, ration Attending Physician: The law require rs after death. at Director: After this certificate has been signed in by the funeral director, page 2 should be striffication: To Be Completed				24a. Was an autopsy	prior to co	opsy findings available empletion of cause of
Reco				performe 1 ✓ Yes 2		2 No
ital Recictan: The sector, page	25. Was case referred to medical examiner? Hospital: 1 Inpatie	ent 2 ER/Outpatient	26.Place of Death (Check 3 DOA Other4 Nursi		sidence 6 🗸 Other:	Scene
of Vi g Physi fter this neral dir	1 V Yes 2 No 28a Date of Inju	ırv 28b. Time of li		28d. Describe how	injury occurred	
ttendir ttendir death. tor: A v the fu	1 Natural 5 Pending FOUND: Day,Y Nov 2, 2011	0150 hrs	1 Yes 2 ✔ No	Subject shot s		
Division o spital or Attending nours after death. neral Director: After filled in by the fune Certification:	Suicide Could not be determined (Specify) Day		et, factory, office building, etc.	or Town State		al Route Number, City Village, MD
Di Hospital 24 hours a Funeral I ttely filled	29a. Certifier 1 Certifying Physician: To the best of m	y knowledge, death occur		d due to the cause(s	and manner as state	d.
To the Howithin 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examiner and manner stated.	mination and/or investigat				
≥	29b. Signature and title of certifier		29c, License number O.C.M.E.		9d. Date signed <i>(Mon</i> November 2, 201	
5	30. Name and address of person who completed cause of d	leath (Item 23a)				
.,	Ling Li, MD Assistant Medical Examine	r 900 W. Baltimoi		1223		
State	31. Date filed (Month, Day, Year) 32. Registra	r's Signature	/			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36523 State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death **Examiner** Anne Arundel Linthicum Heights Tate HospiceHouse Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 F Months Days Hours Feb. 16, 1949 MaryTand **Director** 214-50-0706 62 Usual Residence of Decedent show or 28a-f shov notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Anne Arundel Pasadena Maryland be filed within / ב ייייי antal Hygiene.
Inked other than "natural", or items 23a or 28. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 116 Bar Harbor Road 21122 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 10 N/A Distributor Paper Company permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other i any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ William Foster, Sr. Gloria Isaac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher D. Foster (Son) 1021 Southern Drive Belair Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Atlantic Cremation 11/16/2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Cully-Polyniak Funeral Home, P.A. 04 Mountain Road Pasadena, Maryland 21122 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause a each line. Approximate set and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death 2 No ed by the detached 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has autopsy page certificate 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 1 ည 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA After this 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred DUSF Natural 5 Pending injury work? within 24 hours after death

To the Funeral Director: A
completed filled in by the fu 2 No ☐ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie License number A Name and address of person who cause of death (Item 23 (Type, Print) ANDAPOLIS M.D. 2140 TENEVIEUE LOR CNSE

DHMH 17 Rev 7/2009

Registrar

Date filed (Month, Day, Year,

1. Decedent's Name (First, Middle, Last)

Certificate of Death

Days

Hours

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MOMOH MD,

31. Date filed (Month, Day, Year) - LY 10

2. Date of Death NOVEMBER 4c. County of Death PRINCE GEORGE'S 8. Date of Birth 9. Birthplace (State or Foreign Min AUGUST 27 PA Country) 1926 10d. Inside City Limits 1 XYes 2 No 10g, Citizen of What Country? USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black White etc BLACK 16b. Kind of Business/Industry PRIVATE 18. Mother's Name (First, Middle, Maiden Surname) HETTIE HIGHTOWER DAVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1401 ROSMARY COURT MITCHELLVILLE, MARYLAND 20721 20c. Location - City or Town, State 11/16/11 SILVER SPRING MARYLAND J. B. JENKINS FUNERAL HOME INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 Onset and Death HEART 23d Date of delivery 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 2 🗌 No 28f. Location (Street and Number or Rural Route Number, Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 11-10-2011 D52900

GLENN DALE MD 20769

DHMH 17 Rev 06-2011

State Registrar 12150 ANNAPOUS RO # 205

Other:

work'

1 Yes

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 29d per phy e921 11-16-11 sm State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) November Day Physician/ 201 1:00 P M MEIRA FISHMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE COURTLAND GARDENS BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🛣 F Days Hours Min. (Month Day, Year) 47 Country) NY Director 064-38-2266 64 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 ☐ Yes 2X No BALTIMORE BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Completed by Funeral 21209 2319 FARRINGDON ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ ANo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 XNo Specify Specify. WHITE marked other than "natural", 3 Widowed 4 X Divorced permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **FARBER** FREDA SILVER **JOSEPH** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 CROSBY BLVD., AMHERST. NY SEAN LEWIS/SON 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 X Removal from State CEDAR PARK 11/15/2011 PARAMUS, NJ 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign, ture of Funeral Service Licen. 22. Name and Address of Facility SOL LEVINSON & BROS., INC. ichall 21208 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Pnysician/ Medical disease or condition resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Due to (or as a cons quence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical DOI N F Sh M & L Box 68760 Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of 24a Was an autopsy performe 24 hours after death. Funeral Director: After this certificate has death? 1 ☐ Yes 2 ☐ No Yes 2 V 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 **X**No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2 29d. Date signed (Month, Day, Year) 2011 29c. License number d title of certifier 29b. Signa; R108614 Name and address of person who completed cause of death (Item 23a) (Type, Print) 1
Name and address of person who completed cause of death (Item 23a) (Type, Print) 1
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Name and Address of person who completed cause of death (Item 23a) (Type, Print) 1
Name and 21120 Corwan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Darko 6 Registrar

11-08115 Harry Golden Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 36526

		1- For State Certificate of Death Reg. No.											
Physicia		1. Decedent's Name (First, Midd	ent's Name (First, Middle,Last) 2. Date of							3. Time of Death			
Medical Exami	ner	Harry Golder	n					October	October 29, 2011 0042 hrs				
		4a. Facility Name (if not institution			41	b. City, Town, or L	ocation of E	Death	4c. County o				
		Prince George's Hosp	oital Center			Cheverly			Prince George's				
Funeral		5. Social Security Number	6. Sex 7. Ag	e (In yrs. last l	birthday)	If Under 1 Year Months Days	If Under 2 Hours	24Hrs. 8. Date of B Min.	irth(MM/DD/YYYY)	9. Birthplace (State or Foreign			
Director		577-82-3032	1X M 2 F	5/1961	Country)								
		Usual Residence of Decedent											
#uy		10a. State 10b. County		10c. City, To	wn or Locatio	on				10d. Inside City Limits			
rland -f sbow once.	_	DC		Wash	nington	า				1 Yes 2 No			
aryla 8a-f	支	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	at Country?			
ith the Maryland 23a or 28a-f sho notified at once.	Ö	318 59th Street	NE			2001	10		USA				
with 1 8 23s	Funeral Director	11. Marital Status	12. Was Decedent	Ever in U.S.	13. Was			? (Specify Yes or N		- American Indian, Black,			
eath item	9	1 Never Married 2 N	Armed Forces?	X No	If Ye	s, specify Cuban,	Mexican, P	uerto Rican, etc.)	White	, etc.			
fler d		3 Widowed 4 X Div	vorced If Yes, Giva Year	IAO	1	Yes 2 X No	specify:		Specify:	Black			
urs a tura	d by	15. Decedent's Education (Spe	ecify only highest grade con	npleted) 16		s Usual Occupation			16b. Kind of Bus	siness/Industry			
72 ho	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+)	during mo	st of working life. I	DO NOT us	e retired)					
036 ithin ne.	ם	9th			Chef				Priv	<i>r</i> ate			
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	Harry Lewis (Golden, Sr.				Alic	e Hutchin	ns				
ould d Me	ဥ	19a. Informant's Name/Relations	ship (Type, Print)				and Numbe	er or Rural Route Nu	mber, City or Town				
MD d 2 sho lith and n 27 is		Shalethia Haywo	ood (Daughter	:)	318 59	th Stree	et, N.	E.; Wash	ington, D	City or Town, State			
Tites		20a. Method of Disposition	2 Damauel from St	crer	natory or other	er place)			20c. Location -	City or Town, State			
TO Pages ant of the Literal		1 Burial 2 X Cremation 4 Donation 5 Other S		Ches	apeake	Cremato	ory 1	1/08/11	Beltsvi	ille, Maryland			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygeine. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature Funeral Service			22. Na	ame and Address of	of Facility _T	reeman Fi	noral Co	ravi coc			
E Per De De L		YOUNG THE	eman)		459	4 Reech	Road.	Temple I	Hille M	20748			
Physician		23a. Fart I. Enter the dise Le, or	complications that caused	the death. Do	not enter the	e mode of dying, s	uch as card	liac or respiratory a	rest, shock, or hea	art Approximate Interval			
Medical		Immediate Cause (Final disease		ardiac	arrhy	thmia				Between Onset and Death			
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ited d ansit		events resulting in death) Last	d.	, que 1100 01/.									
Records, P.O. Box 68760, The law requires that the death certificate be executed icate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Physician/Medical	X UNPENDED	AMENDED 23a	-b,27,	per me	,g922 12	-12-1	1 sm					
760, ficate be g physici	3	IF FEMALE:	23c. If yes, outcor	ne of pregnan	icv				23d. Date of	delivery			
187 rtifica ing p	3	23b. Was decedent pregnant in the past 12 months?			2 Feta	al death 3	Ectopic pr	regnancy	Month	Day Year			
Box 68 death certif the attending of for use as	<u> </u>		lunaum H	time of death	5 Oth	er (Specify)			- 1				
the a	اخ		9 Unknown			Contract of the second							
P.O.	J. P	Part II. Other significant condit	tions contributing to death	n but not resul	Iting in the ur	nderlying cause giv	ven in Part I			bute to the cause of death? Probably 4 V Unknown			
Jires I	8		-										
Division of Vital Records, rai or Attending Physician: The law requir is after death. al Director: After this certificate has been sited in by the funeral director, page 2 should	Completed							24a. Was		Vere autopsy findings available prior to completion of cause of			
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tal Recian: The certificate ector, page		25. Was case referred to medica	ıl			26.Place o	of Death (Ch	heck only one)					
n of Vital ding Physician: h. After this certifi	o Be	examiner? 1 Yes 2 No	Hospital: 1 Inpatie	nt 2 🗸 ER	VOutpatient	3 DOA	Other4 N	lursing Home 5	Residence 6	Other:			
of Ning Phy		27. Manner of Death	28a. Date of Inju		b. Time of In	jury 28c. Injury	at Work?	28d. Describe	how injury occurre	ed			
ion of tending Pheath.	힐	1 X Natural 5 Pen	(Month, Day,Y ding	ear)		1 Ye	es 2 No	o					
isicaria i Atternationali i Bytl	Sa		stigation 28e. Place of In	jury - At home	, farm, street	, factory, office bu	ilding, etc.	28f. Location	(Street and Number	er or Rural Route Number, City			
led in	Certification		Id not be rmined (Specify)					or Town,	State)				
Hospi 4 hou Funer		29a. Certifier 1 Certifying P	hysician: To the best of m	v knowledae	death occurr	ed at the time, date	e and place	e, and due to the cau	use(s) and manner	as stated.			
Division To the Hospital or Attendii within 24 hours after death. To the Funeral Director: /	Medical	(Check only one) 2 Medical Exa	miner: On the basis of exa	mination and/o	or investigation	on, in my opinion,	death occur	rred at the time, date	e and place, and d	ue to the cause(s)			
2 € 5 5	Me	29b. Signature and title of certific	and manner stated. er	/		29c License	number		29d. Date signe	ed (Month, Day, Year)			
			MA 17			O.C.M	1.E.		October 30	, 2011			
1. 121		30. Name and address of rsor	who complete cause of d	eath (Item 22-	a)				<u> </u>				
OK Par			outy Chief Medical E			altimore Stree	et, Baltim	ore, MD 21223	3				
- V	ate	31. Date filed (Month, Day, Year)	32 Registra	da Cianatura									
Regist		MOV 1 6 2	199 1	1. 1	barker								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Marida Acquinetta Green 7:02 PM November /Medical 2011 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltin one e.

Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Min. (Month, Day, Year) Haspita Baltimore of N/A Dinai 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1□ M 2□xF 57 Director 219-66-9211 19, 1953 Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, Ite Modical Examinat must be porfited at Director Baltimore 1X Yes 2 □ No N/A Maryland 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21215 2501 Violet Avenue Apt. 1204N USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 _{Specify}. 1 ☐ Yes 2 XNo Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Housewife 11th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be nent of Health and Mental Robert Lee Lovejoy Beatrice Hawkins 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau 3912 Dolfield Avenue Baltimore, Maryland Brenda M. Dailey/Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) |Baltimore,Marylan d 11/14/11 Greenmount Cemetery 22. Name and Address of Facility Chatman—Harris Funeral Home 21. Signature of Juneral Service Licenses 5240 Reisterstown Road Baltimore, MD 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Laternal /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter the control of Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): g physician and stransit the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending p IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mbolu 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ bhknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 2 19 No 1 ☐ Yes Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ne Hospital on 24 hours af the Funeral D 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 8, 2011 D59062 M.A. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) My Hansen Baltimore MA 21215 H.D. 2401 31. Date filed (Month, Day, Year) 32. Registrar's Signature State NOV 1 6 2011 Registrar

DHMH 17 Rev 1/2001

GREEN

AS: MAKINA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G921 / 11/16/2011 Health and Mental Hygiene For State Registrar 36528 Certificate of Death Decedent's Name (First, Middle, Las 2. Date of Death 3. Time of Death Le 30 Physician/ Vovember D poines ra Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore maryland Greneral If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 10001 Day, 1960 Director 28a-f show 10b. County 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location Director Baltimore MD 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number Eutaw Place, 21217 IJSA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life DS NOT use retired)

Beautician (Specify only highest grade completed) Elementary/Saconday (0-12) College (1-4 or 5+) Self Employed Be 17. Father's Name (First, Middle, Last) rvin Gomes Informant's Name/Relationship (Type, Print) (Daughter) 9b. Mailling Address (Street and Numbers of Rural Route Number, City or Town, State, Zip Cooe)

Regina Johnson

2525 Lutaw Place, Apt. 701, 73ulto, MD 21217 20b. Place of Disposition (Name of cometent grematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Baltimore, mo 11-23-11 4 Donation 5 Other (Specify) 2 Vocandidas (Papilli Greene Fuseral Services 5151 Baltimore Nat'l Pike (21229) 21. Signature of Funeral Service License Vaughn C. Heere 5151 Baltimore Nat'17.

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Farlure Physician/ Heart disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury expentitution Indrome that initiated events resulting in death) Last physician at the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 use as signed by the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 1 Yes 2 g Unknown a | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 ☑ No 3 ☐ Probably 4 ☐ Unknown . Were autopsy findings available prior to completion of cause of 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has autopsy death? 1 Yes 2 No 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 2 🗷 No Other: ည 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ZEESHAN AL 11/13/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) racyland General Hospital ZeeshanAli, m D. 40 Registrar's Signatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ GITTURE UISE 1042AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSPITAL BALTIMORE 5. Social Security Number 6. Sex 8. Date of Birth Jan 3, 1929 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 🔀 F Maryland Director 82 218-66-1546 Jan Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, <u>the Medical Examiner must be notified</u> at **Funeral Director** 1 Yes 2 X No Baltimore MD Reisterstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14117 Hanover Pike 21136 U.S.A. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. Be Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: 3 XWidowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event. The Man College (1-4 or 5+) Elementary/Seconday (0-12) 12 Housewife Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Raymond Brown Elsie Hale 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randy G. Gittere Son 16 Chatsworth Avenue Glyndon, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/17 /11 Evergreen Mem Park Finksburg, Maryland Signature of Funeral Serylice Licensee 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Bower ISCHEM disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Day Pregnant at time of death g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🖰 No 1 T Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 🗹 No Other: မူ 1 Tes 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 252 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MURRA 5401 COURT RD RANDALLSTOWN MD 21133

State Registrar

31. Date filed (Month, Day, Year)

1 6 2011

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ Month 41184 NOV ANNMedical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner Baltimore City** BALTIMORE HARBOR HOSPI If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) (Month, Day, Year)

Jan 10, 1952 **Funeral** Days 1 🗆 M 2 💢 F Hours Min. Country) MD 212-58-9173 59 Director Yrs Usual Residence of Decedent f show 10d. Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10a. State with the Maryland Director Glen Burnie 1 Yes 2 No MD **Anne Arundel** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. Funeral 21061 432 Valiant Circle permit. Page 1 and 2 should be filed within 72 hours after death Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: 3 🗆 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Disabled Disabled 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Anna Margaret B. Rapp Richard R. Morris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 432 Valiant Circle Glen Burnie, MD 21061 John C. Gray spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veterans Cemetery Crownsville, MD Nov 17, 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Simpleture of Furieral Service Licensee 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) RENAL MOUFICIONC 6 YEAR Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to for as a consequence of PANCREATITI the Hospital or Attending Physician: The law requires that the death certificate be executed CHRONIC Cause (Disease or linjury signed by the attending physician and defached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last DIABETES Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? After this certificate has autopsy performed 1 🗌 Yes 2 🗌 No 1 ☐ Yes 2 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one) filled in by the funeral director, Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 1 🗌 Yes Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work?
1 Yes 5 Pending 2 🗌 No 24 hours after death. Funeral Director: Al Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined 1 Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventigation in a property of the proper Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D72410 Kuliama Velgo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

CM

32. Registrar's Signature

S. HANOVER ST

BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36531 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Lot P 2019 GORDON MAX Notember Medical 4a. Facility Name (if not institution, give street and number)

SIN al 10 Pital + Baltimore 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore CITY N/A Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** Hours 215-07-3949 **Director** 1 XM 2 □ F 93 09/02/1918 **GERMANY** 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🕱 Yes 2 □ No N/A BALTIMORE 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a of the Medical Examiner must be Funeral 2434 W. BELVEDERE AVENUE 21215 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, rmed Forces?
XYes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: Specify Completed 3 ¥ Widowed 4 □ Divorced WHITE Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than College (1-4 or 5+) 5+ Elementary/Secondary (0-12) DENTIST MEDICINE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ traumatic BERKO GORDON IDA BEKER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau JACOB L. GORDON/SON 1310 KANSAS AVENUE, WHITE OAK, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State LUBAWITZ NUSACH ARI 4 ☐ Donation 5 ☐ Other (Specify) 11/15/2011 BALTIMORE, MD (NER TAMID) CEM 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Matt 1eu 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ S 81515 disease or condition days Medical resulting in death) Due to (or as a consequence of) Examiner dars Tultisyeom Or +417 FullVie Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Polamichbi Q days Sepsis that initiated events Due to (or as a consequence of) resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 as the k d. IF FEMALE use yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ for in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day Pregnant at time of death by the signed by the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ate has bade 2 s autopsy performed? Yes 2 2 X No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) After t 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) RES-000 Notember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 SUNNOL MO 32. Registra's Signature 31. Date filed (Month, Day, Year, State NOV 1 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date df Death Physician/ Medical 4a. Facility Name (if not institution, give street and nu **Examiner** If Under 8. Date of Birth 9. Birthplace (State or Foreign 214-40-2344 **Funeral** (Month, Day, Year) Country) Director 1 XM 2 🗆 F 67 N/A 02/11/1944 28a-f show 10a. State 10h. County 10c. City. Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD N/A Baltimore 1 XYes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 6847 Parsons Ave. 21207 U.S.A. death 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White, etc. is marked other than "natural", or Completed by 1 Never Married 2 Married Yes Yes, Giv 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade College (1-4 or 5+) Janitorial Franklin Sq. Hosp. 7. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James B. Green Lucille Henson injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Joanne Burriss(sister) 6847 Parsons Ave., Baltimore, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or otl ☐ Burial 2x Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) on-site Crematory 11/14/11 Baltimore, eral Service Licensee ph^{Address of Egullo}wn Jr. Funeral Home PA N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burial physician s the buria Physician/Medical P.O. Box 68760 IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? jo Pregnant at time of death ed by the a g | Hnknown g Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 1 Yes 2 No has page death? 2 🗌 No ren Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 00 1 Tyes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 3 ☐ Sulciue 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier 12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur of de (Item, 23a) (Type, Print) State Registrar

11-08502 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Shelby Renee Hall State of Maryland / Department of Health and Mental Hygiene 36533 2011 1- For State Certificate of Death Registrar Physician/ 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death M-ędical Examiner Shelby Renee Hall Month Month Day November 12, 2011 1051 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3800 W. Belvedere Avenue **Baltimore** 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director 218-86-7896 50 Hours 11/12/62 1 M 2 F Country) Usual Residence of Decedent in 10a, State 10b. Count 10c. City, Jown or Location Baltimore 10d. Inside City Limits N/A MD 28a-f show 1 Yes 2 No Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23s or 28s-f she or other traumatic event, the Medical Examiner must be neithed at one. 10e. Street and Number 10g. Citizen of What Country? 3800 W. Belvedere Ave #904 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married Armed Forces? White, etc. African 2X No Yes 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Š Specify: Amer. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Self Baltimore, MD 21215-0036 10 Homemaker 17. Father's Name (First, Middle, Last)
Calvin Hall 18.Mother's Name (First, Middle, Maiden Surname) Juanita Hall 19a. Informant's Name/Relationship (Type, Print)
Ray Lynn Hall/Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1222 Violet Hill White Way, Balt., MD 21201 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) 11/19/11 Balt., MD Mt. Zion Cem 4 Donation 5 Other Specify 22. Name and Address of Facility Hari P. Close F. Svs, PA 21. Signature of Funeral Service License 5126 Belair Rd, Balt., MD 21206-5105 **Physician** Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval failure. List only one cause on each line **⊘** Medical ween Onset and aminer Immediate Cause (Final disease a Cardiomegaly Death or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and transit Physician/Medical X UNPENDED AMENDED 23a, 27, per me, g923 1-20-12 sm attending physician or use as the burial The law requires that the death certificate be Records, P.O. Box 68760. IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy past 12 months? Month Day Year Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 ✓ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? Yes 2 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi director, 25. Was case referred to medical Division of Vital 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗹 Other: Scene 1 🗸 Yes funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural after death.

Director: / 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 28f. Location (Street and Number or Rural Route Number, City Could not be or Town, State) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 13, 2011 peral 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36534 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 12:45 P^M 2011 November Mary Catherine Harris Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Bel Air 1616 Cass Drive 9. Birthplace (State or Foreign Country)

Maryland 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) une 22, 1935 1 □ M 2 🛣 F Months Hours 76 June Director 220-30-6379 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔀 No Harford Bel Air Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe Completed by Funeral USA 21015 1616 Cass Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Force 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Health Insurance Customer Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Alma Pauline Mask Joseph Clinton Owen Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1616 Cass Drive, Bel Air, Maryland 21015 Robert Harris / Husband other Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Gardens of Faith Cem. 11/14/2011 Donation 5 Other (Specify) 4 E Funer Service Lice ee 22. Name and Address of Facility 21. Sig McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Part 1. Enter the disease, or complic shock, or heart failure. List only one Onset and Death Immediate Cause (Final Pnysician/ Non itob 6 kt ns ct ~ Pitom A year disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list no callers if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IE FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live Birth 2 - Fetal death in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 🗌 No 1 ☐ Yes 2 ☐ Unknown s been signed by the same should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2-No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 IER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. ☐ Accident ☐ Suicide Investigation within 24 hours after death

To the Funeral Director: / 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. з 🗆 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number nowander 11 00058475 PITTSILITAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1DV NEVATRINEU uppromediated system no 210 PHEUIP nth, Day, Year) NOV 1 6 2011 Registrar's Sign State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar		(Certifica	ate of	Death				Reg. No			
Physicia Medical Examir		1. Decedent's Name (First, Midd Karen Hass		ar	-					. Date of De Month Novembe	Day	Year 2011		3. Time of Death 1420 hrs
		4a. Facility Name (if not institution Franklin Square Hosp	on, give street and no			4	4b. City, Town, or Location of Death Towson				4	c. County of		ntv
E		5. Social Security Number	6. Sex	7 Age (lov	re last hirth	aday)		or If I loc	lor 2/lUre	9. Data of F				
Funeral Director		212-90-2195	12 00 210E									Foreign		
any.		Usual Residence of Decedent 10a. State 10b. County		10c. (City, Town o	or Location	on							10d. Inside City Limits
	į		timore		P	arkv	ville							1 Yes 2 No
with the Maryland ms 23a or 28a-f sho be notified at once	Director	10e. Street and Number 3040 Cal	ifornia	Aven	ue		10f. Zip Code 212	34			10g. Cit	tizen of Wha	at Coun	try?
ath with items 23	Funeral	11. Marital Status 1 Never Married 2 X M	arried Armed F				Decedent of Fes, specify Cub				0-	14. Race - White,		can Indian, Black,
after de	by Fu	3 Widowed 4 Div	orced If Yes, Give Yes or Dates:	2 X N ar			Yes 2X N					Specify:	Bla	ck
ours	풽	15. Decedent's Education (Spe		de completed	d) 16a. D	ecedent	's Usual Occup est of working li	ation (Give	kind of wor	k done	16b.	Kind of Bus	iness/Ir	ndustry
036 ithin 72 h ne. r than "n	Completed	Elementary/Secondary (0-12) 12th	College (aker	e. DO NO	use retired	<u>.</u> ,		Home		
21215-0036 uld be filed within 72 hours afte Mental Hygiene. marked other than "natural", c event, the Medical Examines	Be Co	17. Father's Name (First, Middle, Clyde Hall	Last)							First, Middle, Wid				
2 2 2 2	0	19a. Informant's Name/Relations Mohammad Reza	hip (Type, Print) A Hassan Hus	iafsh	19b.	Mailing	Address (Street)	et and Nur	mber or Rur a Ave	ral Route Nu	umber, C	ity or Town	State,	Zip Code) 1 2 3 4
Baltimore, MD 's permit. Pages I and 2 shou Department of Health and I Important: If item 27 is a injury or other traumatic.		1 Burial 2 Cremation	n 3 Removal fr	20	ub. Place of	DISDOSII	tion (Name of c	emeterv.		Jare	20C.	Location - (City or I	Fown, State e , MD
Baltimore, permit. Pages I an Department of He Important: Wite Important: Wite Imjury or other tr		4 Donation 5 Other Sp 21 Signature of Funeral Service				22. Na 2.7 (ame and Addre	ss of Facilit	L Beve	rly d	D=1 #	Croma	—	i ₂
Physician	4	23a Part I. Enter the disease, or	complications that of	aused the de	eath. Do not									Approximate Interval
Medical Examiner		failure. List only one cause Immediate Cause (Final disease	on each line. a. Cardia	c Arrh	nythmi								j	Between Onset and Death
	-	or condition resulting in death) Sequentially list conditions,	Due to (or as a			sis							9	
	mine	if any, leading to immediate cause. Erner Underlying Cause												
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8760, tificate be ex ng physiciar as the burial	₽.	IF FEMALE: 23b. Was decedent pregnant in th		outcome of p					_		23	d. Date of d	,	
Box 68' e death certifi the attending ed for use as r	Physician	past 12 months? 1 Yes 2 No 9 ✔ Unk	4 Pregr	nant at time o	of death 5		al death 3 er (Specify)	Ectopi	c pregnanc	у	2	Month	Da	ay Year
O. Bo at the de by the	돌	Part II. Other significant conditi	9 Unkik		ot resulting	in the ur	nderlying cause	given in Pa	art I.	23e. Did	tobacco	use contrib	ute to t	he cause of death?
ires that the signed by	<u> </u>	Chronic Alcoh								1 Y	es 2	No3	Proba	ably 4 🗹 Unknown
of Vital Records, or Physician: The law require ther this certificate has been sineral director, page 2 should be	Completed									24a. Was auto	psy	pri	ior to co	opsy findings available empletion of cause of
tal Rec	팅			15						1 Yes	ormed?		eath? Yes	2 No
ician: The scertificate rector, page	Be	25. Was case referred to medical examiner?	11 0 1		Te spice i			-	(Check onl		l	ence 6	l au	
Of V ing Phys After this	의	1 ✓ Yes 2 No 27. Manner of Death	28a, Date	Inpatient 2 of Injury		ime of In		ury at Worl				ury occurre		
ion (trending leath.	atio	1 X Natural 5 Pend 2 Accident Inves		, Day,Year)			1	Yes 2	No					
Division pital or Attendin ours after death. eral Director: A	Certification:	3 Suicide 6 Could		e of Injury - A	At home, far	m, street	, factory, office	building, e	tc. 28	or Town,		and Number	or Rura	al Route Number, City
	Medical C	29a. Certifier 1 Certifying Ph	nysician: To the bes	of examinatio										
To vii	ğ	29b. Signature and title of certifie	and manner s	rated.			29c. Licer	se number			29d.	Date signed	d (Mon	th, Day, Year)
		Une ZZ_	•				0.0	.M.E.			Nov	vember 1	1, 20	11
		30. Name and address of person Ana Rubio MD. Ass	istant Medical I	Examiner	900 W	. Baltir	nore Street	, Baltimo	ore, MD 2	21223				
Sta Registr	12:4	31. Date filed (Month, Day, Year)		egistrar's Sigr	nature	rack	1							

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36536 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:25 November 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Larrol Hospital Center Carrol1 Westminster Social Security Number Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 M 2 X F Hours Min. 3/30/1936 218-32-1683 Director 75 MD Usual Residence of Decedent 28a-f show 10b. County marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carrol1 Woodbine 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 7638 Old Washington Rd. 21797 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🖾 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 ⅓ Widowed 4 ☐ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Important: If item 27 is marked other the any injury or other traumatic event, the 12 Housekeeper Fairhaven Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ild be file Mental F ٥ Mildred Fleming Paul Beaver permit. Page 1 and 2 should Department of Health and M Imnortant: If item 27 is man 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7638 Old Washington Rd., Woodbine, MD 21797 Jerry Paul Hymiller/Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🛣 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 11/17/2011 Poplar Springs, MD Poplar Springs Cem. 21. Sign of Funeral Service License ²Burrier Outern Funeral Home & Crematory, P.A. 1212 W. Old Liberty Rd., Winfield, MD 21784 MM 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Saure (Final disease or condition resulting in death) Onset and Death Physician/ Dulmonary Medical Examiner Esquentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Exami Coronar nding physician and ise as the burial-tran Physician/Medical death certificate be Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Po Pregnant at time of death Month Day Year ed by the a detached f Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy perform death? rmed? 2 M No 2 🗌 No Yes 1 Yes of Vital To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No 1 Yes Other: ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director, After thi completed filled in by the funeral of 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? Division 2 🗆 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Fractioner: To the best of my knowle 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D00647 MDNovember 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 101 Naveed Shah 826 Washington Blvd., Suite 130, Westminster, MD 21157

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Bay, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36537 Certificate of Death 1. Decedent's Name (First, Middle, 2. Date of Death 3. Time of Death Physician/ Morth Hess ndvew Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death och Roven Community Living N/A Raltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) 8. Date of Birth Months Days Hours 1 ፟ M 2 □ F 05/14/1922 Mary Land 89 216-16-1540 **Director** Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore 1 Tes 2 No Maryland Catonsville 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? and 2 should be filed within 72 hours after death with the Health and Mental Hygiene.
If marked other than "natural", or items 23a and ther traumatic event, the Medical Examiner must be Funeral 312 Greenlow Road 21228 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☒ Yes 2 ☐ No If Yes, Give ₩₩TT Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced White Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mail Clerk Postal Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles L. Hess, Sr. Ruby Anna Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 3407 Oak West Drive Ellicott City, Maryland 21043 Barbara Jenkins - Daughter item 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify Filandment Loudon Park Cemetery 11/15/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Dayld J. Weber Funeral Homes P.A. 5311 Famondson Avenue Baltimore, Maryland 21229 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Part 1. Enter the disease Approximate Interval Between wease Immediate Cause (Final disease or condition Onset and Death Physician, vonav Medical resulting in death) Due to (or as a consequence of): Examiner emen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 2 No 9 Unknown eate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Completed 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No autopsy this certificate completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No HOSPICE မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work?
1 ☐ Yes 24 hours after death. Funeral Director: After t 28d. Describe how injury occurred 1 Matural 5 Pending 2 🔲 No Accident Suicide Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29d. Date signed (Month, Day, Year) 41365 of death (Item 23a) (Type, Print) 3900 B och Raven altimove Registrar's Signatu State

DHMH 17 Rev 7/2009

Registrar

		For State Registrar			naryiano	Cer	artment of tificate of	Death	and M	R	eg. No.	011	3653	
ician/	1	Decedent's Name Esther J		,		2. Date of I Month Nov •						2011	3. Time of Death 5:35 p M	
miner		Arlingto	on West	give street and number) Nursing Ho		4b. City, Town, or Location of Death Baltimore						4c. County of Death N/A		
ral tor	L	Social Security Nu 220-14-1 Usual Residence of	349	1 □ M 2 M F	ge (In yrs. Ia:	ge (In yrs. last birthday) 86 Yrs. If Under 1 Year If Under 24 Hrs. Months Days Hours Min.					(Month, Day, Year)		Birthplace (State or Foreign Country) Virginia	
Director	- 1	0a. State	10b. County		10c. City, Town or Location Baltimore						10d. Inside City Limits 1 M Yes 2 ☐ N			
Funeral Di	1	0e. Street and Num		se Avenue		10f. Zip Code 21215					10g. Citizen of What Country? USA			
ed by Fun		Marital Status Wever Marri Widowed		12. Was Decedent Armed Forces' 1 Yes 2 If Yes, Give Year or Dates.	?/	If Yes, specify Cuban, Mexican, Puerto Ricar					No- 14. Race - American Indian, Black, White, etc. Specify: Black			
once. To Be Completed by Funeral Director		(Special Special Speci	ondary (0-12)		5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Food Service Worker						16b. Kind of Business/Industry Baltimore City Public Schools		
To Be		7. Father's Name (F Edward J		st)					Mont	(First, Middle, Mague	1aiden Surna	me)		
	L		ılker -	Daughter		7 Dee	ng Address (Stree p Spring			stersto	wn, Ma	rylan	d 21136	
	L	20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Western Star Cem. 20c. Location - City or 1 Catonsville										ville	, Maryland	
ouce	2	1. Signature of Fur	neral Service Lid	Tirii			. Name and Addr 240 Reis							
er Examiner	I control of the cont	shock, or hear immediate Cause (I disease or condition resulting in death) Sequentially list configure, leading to im- cause. Enter Under Cause (Disease or I that initiated events	rtrailure. List on Final in Inditions, imediate Hyling Injury	,	ne. S a conseque NON	PACE of):	SE 10	EN.	AL	-	EA		Approximate Interval Between Onset and Death	
_	r	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)								23d. Date of delivery Month Day				
ysician/Me	2	1 Yes 2	months?	1 Live Birth	at time of de			псу					Day Year	
d by Physician/Medical	۱۲	1 Yes 2 g Unknown	months?	1 Live Birth 4 Pregnant	at time of de	eath 5	Other (specify)		I.		pacco use co		he cause of death?	
Completed by Physician/Me	۱۲	1 Yes 2 g Unknown	months?	1 Live Birth 4 Pregnant 9 Unknown	at time of de	eath 5	Other (specify)		I	1 Ye	pacco use co	3 Pro	he cause of death? bably 4 Dunknov psy findings available mpletion of cause of	
b Be Completed by Physician/Me	25	1 Yes 2 g Unknown Part II. Other signifi 5. Was case referre examiner?	months? No icant condition	1 Live Birth 4 Pregnant 9 Unknown s contributing to death	at time of de	eath 5	Other (specify)	piven in Part	ath (Check	1 Ye 24a. Was ar autops perforr 1 Yes only one)	pacco use copes 2 No	b. Were autoprior to codeath?	he cause of death? bably 4 Dunknov psy findings available mpletion of cause of 2 □ No	
tificate: To Be Completed by Physician/Me	2:	1	months? No icant condition and to medical No 5 Pending Investiga 6 Could no	1 Live Birth 4 Pregnant 9 Unknown s contributing to death Hospital: 1 Inpa 28a. Date of in (Month, D)	at time of de but not resultient 2 I fijury	eath 5 Lilting in the u	26. Int 3 DOA Ot	Place of Dea her:	ath (Check ursing Hor 2	1 Ye 24a. Was ar autops perforr 1 Yes 2 only one) me 5 Reside 86d. Describe ho	pacco use consess 2 No	b. Were autoprior to codeath? 1 Yes	he cause of death? bably 4 Dinknow psy findings available mpletion of cause of 2 \sum No	
lical Certificate: To Be Completed by Physician/Me	2:	1 Yes 2 g Unknown Part II. Other signifi 5. Was case referre examiner? 1 Yes 2 7. Manper of Death 1 Accident 3 Suicide 4 Homicide	icant condition ided to medical No S Pending Investigated Country Acceptifying Investigated	Hospital: Hospital: 1 Inpa	but not resultient 2 If jury ay, Year)	ER/Outpatier 28b. Time of injury ne, farm, stre	other (specify) 26. Int 3 DOA 28c. Inju wo 1 Deet, factory, office	Place of Deather:	ath (Check ursing Hor 2 No	1 Ye 24a. Was ar autops perform 1 Yes 2 only one) me 5 Reside 28d. Describe ho 28f. Location (Str. City or Town	pacco use codes 2 Notes 2 Note	b. Were autoprior to co death; 1 Yes other (Specification of Rural anner as state)	he cause of death? Ibably 4 Dunknow Ibably 4 D	
To Be Completed by	2: 2: 2: 2: 2: 2: 2: 2: 2: 2: 2: 2: 2: 2	1 Yes 2 g Unknown Part II. Other signifi 5. Was case referre examiner? 1 Yes 2 Yes	icant condition icant condition ad to medical No 5 Pending Investiga 6 Could nodetermin Certifying I	1 Live Birth 4 Pregnant 9 Unknown s contributing to death Hospital: 1 Inpa 28a. Date of in (Month, D) 28e. Place of Ir building, e	at time of de but not resultient 2	ER/Outpatier 28b. Time of injury ne, farm, streedage, death of and/or investigations.	26. Int 3 DOA Ot 28c. Inju wo M 1 Deet, factory, office	Place of Dea her: Yes 2 ne, date and ion, death o the time, date	ath (Check ursing Hor 2 No 2 place, an	1 Yes 24a. Was ar autops performed to the series only one) me 5 Reside 28d. Describe how the series of the ser	pacco use codes 2 No No 241 Street and Num A state) In the code of the code	b. Were autoprior to cocdeath? 1 Yes https://doi.org/10.1001	he cause of death? Ibably 4 Dunknow Ibably 5 Ibably 6 I	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 58 P M Medical 4a. Facility Name (if not institution, Examiner 4c. County of Death N/A HEA 405 8. Date of Birth (Month, Day, June 1 9. Birthplace (State or Foreign **Funeral** 1 M 2 X Months Davs Min. Hours 216-16-7558 Virginia Director 191B June Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director N/ABaltimore Yes 2 No Maryland 10e. Street and Number 10f. Zip Code ō 10a. Citizen of What Country? Funeral or items 23a USA 21239 1516 Pentwood Road within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian traumatic event, the Medical Examiner Armed Forces Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No ģ Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Defense Dept. Seamstress Be and 2 should be filed 17. Father's Name (First, Middle, Last) (18. Mother's Name (First, Middle, Maiden Surname, nd Mental ည Charles Law Linda Watson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 Park Road Perry Hall, Maryland
21128 and l 19a. Informant's Name/Relationship (Type, Print) Sharon Barnes/ Granddaughter item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Page 1 Department of Important: If it any injury or o once. 1 Burial 2 🔀 Cremation 3 🗆 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery 11/9/11 Baltimore, Maryland 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore, MD 21215 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last Exan Due to (or as a consequence of) the attending physician Physician/Medical certificate be Box 68760 as the l IF FEMALE: use ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 month 1 Yes 2 No Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) detached for Month Year Pregnant at time of death 1 L Yes 2 E 9 Unknown P.O. þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform certificate 1 Yes 2 No 1 Yes 2 Division of Vital To the Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death Check only one examiner? 2 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Director: After this 27 Manner of Peatl 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural work?
1 Yes 5 Pending death. 2 🗌 No filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours after To the Funeral Direct Medical 29a. Certifiei Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed rcal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check ertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signat Wallhan woods Rd #204 PARKU, IK HD 31. Date filed (Month, Day, Year) State

Registrar

NOV 1 6

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36540 Certificate of Death Reg. No. nt's Name (First, Middle, Last) 2. Date of Death Physician/ Medical a. Facility Name (if not institution give street and number. **Examiner** 4c. County of Death 8. Date of Birth Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** 02/25/1947 64 MD **Director** 1 M 2 XF 28a-f show 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore s 23a or 22 1X Yes 2 No 10e. Street and Number 10f. Zip Code 21239 10g. Citizen of What Country? E. Northern Parkway Funeral USA must items 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injuy or other traumatic event, the Medical Examiner. Black, White, etc ò 1 Never Married 2 Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify:Black Completed 3 Widowed 4 X Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Healthcare Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hazel Johnson ဂ္ Reilly Bryant 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14314 Burbank Blvd., Sherman Oaks, CA 91401 Anthony Jackson / 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State Atlantic Crematory or other place; 11/13/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) Funeral Service Licensee Dorota Marshall Maryland Cremation Services PO BOX 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Interval Between Onset and Death Immediate Cause (Final Mid Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examine Due to (or as a consequence or). if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-tran and Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No-24a, Was an After this certificate has autopsy Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 No Hospital: 1 🗌 Yes Other ၉ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending Accident Investigation within 24 hours after deatl To the Funeral Director.. 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur 29d. Date signed (Month, Day, Year) who completed of death (Item 23a) (Type, Print) 31. Date filed State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36541 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death William Wallace Jenna Physician/ November 9, 2014 9:55 PM Medical 4a. Facility Name iff not institution, give street and numbers 220 Timber Trail, unit E 4b. City, Town, or Location of Death Bel Air 4c. County of Death Hartford **Examiner** 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 077-22-7336 6. Sex 1**X** M 2 □ F 7. Age (In vrs. last birthday) **Funeral** Days Hours 80 0492274931 Director Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Harford Bel Air 1 X Yes 2 No 10e. Street and Number 220 Timber Trail Unit E 10g. Citizen of What 10f. Zip Code 21014 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XXves 2 □ No Army If Yes, Give Year or Dates. 1952-54 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 X Married 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify. Specify: White "natural", 3 Divorced 4 Divorced Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant: If item 27 is marked other than "natur iury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Professor Education Be 18. Mother's Name (First, Middle, Maiden Surname, Maude Whiteside 17. Father's Name (First, Middle, Last) William Jenna 19a. Informant's Name/Relationship (Type, Print)
Saron Jenna / Spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saron 220 Timber Trail, Unit E., Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State At lantic cremeters of their place! 11/11/2011 Glen Burnie, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Waryland Cremation Serv
PO Box 1413, baltimore, 21. Signature of Funeral Service Licensee Darota Marshall Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate 23a. Part 1 shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ Meta Cancer of disease or condition resulting in death) Medical Examiner Unknown 2011 Segrentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam ending physician and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ signed by the atter d be detached for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s has autopsy performed' death? • Hospital or Attending Physician: The | 24 hours after death. • Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 1 Yes 2 🖼 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bel Air, MI) 2014 Tollgate Rd TOR MD

DHMH 17 Rev 7/2009

State Registrar

11-08322 Kelly John

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 36542 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day November 6, 2011 Kelly R. John 2044 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Baltimore** Harbor Hospital Center If Under 1 Year If Under 24Hrs. 8, Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Director Months Hours 176 64 6978 06/01/1982 29 Country) PA 1X M 2 F Vrs Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Maryland Anne Arundel Annapolis 1 Yes 2 X No t. Pages 1 and 2 should be filed within 72 hours after death with the Maryland trnent of Health and Mental Hygiene.

Trant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. Director 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? 131 Jennifer Road U.S.A. 21401 Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married 2 X No 1 Yes f Yes, Give Year or Dates: White 3 Widowed 4 Divorced 1 Yes 2 X No specify: Specify: 2 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Commercial Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 12th Residential Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles B. John Rebecca E. Davis æ 19a. Informant's Name/Relationship (Type, Print) ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles B. John / Father 980 Schoolhouse Drive Ashville, PA. 16613 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 X Removal from State 11/11/2011 Forsht Cremation Altoona, PA 4 Donation 5 Other Specify: permit. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Gonce Funeral Service, P.A. ma Baltimore, Maryland 21225 Ritchie Highway 23a Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Madica Death a Narcotic Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED 23a, 27, 28a-f, per me, g921 11-18-11 sm attending physician a X UNPENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy 2 Fetal death Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? this certificate has been signed if director, page 2 should be detr 2 1 Yes 2 No 3 Probably 4 ✓ Unknown pleted 24a Was an 24b. Were autopsy findings available prior to completion of cause of performed? ✓ Yes 2 No Com death? page 1 Yes 2 No Hospital of Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) å Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: 1 🗸 Yes 28a. Date of Injury (Month, Day, Year After 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 1 Yes 2 X No 5 Pending unknown death. Director: fd 11-3-11 fd 21:18 Investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5808 Ritchie Hwy. 28e. Place of Injury - At home, farm, street, factory, office building, etc. hours after 6 X Could not be 3 Suicide within 24 hours at To the Funeral D determined (Specify) Convenience Store Brooklyn Park, Md. Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c License number November 7, 2011 O.C.M.E llan 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Carol Allan, MD

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signatur

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Year Month **Physician** November 2011 norris /Medical 4c. County of Death 4b. City, fown, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Sept 27, 1 5. Social Security Number . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🕅 M 2 🗆 F 55 Sept 1956 Maryland **Director** <u>218-72-</u>6413 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State items 23a or 28a-f show ner must be notified at 1X Yes 2 ☐ No Funeral Director Harford County Bel Air Maryland 10g, Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 21014 941 Buckland Place Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Examiner and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 X Married 2 X No Baltimore, Maryland 21215-0036 ŗ, 1 ☐ Yes 2 X No Specify: White Specify. þ 3 ☐ Widowed 4 ☐ Divorced "natural" Completed | 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) other than "naturent, the Medical (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Electrical Services Self Employed/Owner 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Grace Alice Euler is marked John Norris Jones, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 941 Buckland Place, Bel Air, Maryland 21014 Health a Whitney D. Wilkins (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State Green Mount Crematory 11/15/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signatule of Fundal Service licensee MITCHELL WIEDEFELD FUNERAL HOME, Martin D. Lawson 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death))/Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No 2 No 1 Yes 1 Yes Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident Injury 5 Pending 1 🗌 Yes 2 🗆 No investigation 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (check only within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

Box 68760.

P.O.

Division of Vital Records.

DHMH 17 Rev 1/2001

600 North Wolfe St, Baltimore, MD, 21287

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EMILY A. ROGERS

72. Registrar's Signature

31. Date filed (Month, Day, Year)

NOV 1 6 2011

r this certificate has been signed by the al director, page 2 should be detached for To the Hospital or Attending Physician: Division of Vital After death. To the Fuoeral Director: 24 hours after

Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) FOUND: 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Subject shot self FOUND 1 Natural 1 Yes 2 ✓ No 5 Pending Nov 12, 2011 2330 hrs 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 V Suicide Could not be or Town, State) 3716 Keene Avenue, Baltimore, MD determined (Specify) Townhouse / Rowhouse Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifier 29c. License number November 13, 2011 O.C.M.E. allan 30. Name and address of person who completed cause of death (Item 23a)

OCME

ORIGINAL

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

Jarka

State

Registra

Carol Allan, MD 31. Date filed (Month)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36545 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1:45 PM DONNA L . KESTON 06 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner SAMARITAN BALTIMORE HOSPITTL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 □ M 2 □ F Director 10/28/1959 216-74-6658 New Jersey Usual Residence of Decedent 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 □ No N/A Baltimore MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō death with 21206 5425 Todd Ave. 23a USA Funeral or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

1s marked other than "natural", or ite 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: Black à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12th Care Giver yrs. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Mae Conner Eugene Martin ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health an Important: If item 27 Is r any injury or other traur Micheal Lucas - Son 3504 Erdman Ave. Baltimore, Maryland 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 █ Burial 2 ☐ Cremation 3 ☐ Removal from State 11/12/2011 Randallstown, MD King Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Spal Muller Baltimore, MD 21202 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician HENDER HAGE INTRA CRANIAL HOURS disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner YEARS H YPERTENSION Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) the attending physician hed for use as the buria Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □Yes 2 ☑No Day Month Year 5 ☐ Other (specify) 9 Unknown 9 Unknown certificate has been signed by rector, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 ☑No 24a. Was an autopsy performed? director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 ☑ No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification; To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 31. Date filed (Month, Day, Year) NOV 1 6 2011

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FUHER

29b. Signature and title of certifier

LORI-ANN

32 Registrar's Signature

G000

DHMH 17 Rev 1/2001

29c. License number

SAYARITAN HOSPITAL,

RES 000

29d. Date signed (Month, Day, Year)

2011

LOCH RAMEN GUD 21239

06

5601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 9 Physician/ 10 AM CHANG GOO KANG Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** (2 U Gun G General Columbi toward trolla loward If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) Yrs. 8. Date of Birth **Funeral** Months Davs Hours VI-eo Director Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director Howari notified 1 🗌 Yes 2 💢 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò ritems 23a or ner must be n Funeral GA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces 1

1 Yes 2 No Black, White, etc. ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Asial If Yes, Give Year or Dates Specify "natural", Completed 3 Divorced 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Megonee. Elementary/Seconday (0-12) College (1-4 or 5+) restauran OWNER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 ILNK 21042 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) nam 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, Mourid 11-2011 Signature of Funeral Service 0220 101 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death EPSIS Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of); PNEUMONI A Examiner ERAC Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No page 2 should be detached for Month Dav 5 Other (specify) the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe has within 24 hours after death.

To the Funeral Director: After this certificate 1 Yes 2 No Yes director, 25. Was case referred to rical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 🗌 Yes Certificate: To inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28b. Time of completed filled in by the funeral 28a. Date of injury 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🛂 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3064

Registrar DHMH 17 Rev 7/2009

J W

Back REVER MICK

Road Ballmyx May

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ramesh Sabapalin 201-(09)

32. Registrar's Sign

amesh

6 2011

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible, State of Maryland / Department of Health and Mental Hygiene 36547 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 1 13, 20**1**1 2:45 P.M Alexander Felix Kaufman Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Cockeysville Broadneed Retirement Community Date of Bill. (Month, Day, Yea 28, 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 **X**M 2 □ F Days Hours Min. 058-18-4066 84 Yrs New York **Director** Feb. Usual Residence of Decedent 10a. State 10b. County aţ 10c. City, Town or Location 10d, Inside City Limits Director "natural", or items 23a or 28a-f s idical Examiner must be notified Maryland Baltimore Cockeysville 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 21030 13801 York Road America Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married 72 hours after 21215-0036 white If Yes, Give Year or Dates 1 Tes 2 No Specify: Specify Completed 3 Widowed 4 Divorced event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Chesapeake Bay Elementary/Seconday (0-12) College (1-4 or 5+) Ship's Captain Pilot marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೨ unk. unk. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, S Page 1 and 2 sl ment of Health a tant: If item 27 is ury or other tra Mrs. Eleanor A. Kaufman/ wife 13801 York Road Cockeysville, Maryland 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November permit. Page 1
Department of Important: If it any injury or o cemetery, crematory or other place)
Evans Funeral
hapel – Bel Air 1 ☐ Burial 🍇 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 2011 21. Signature of Faheral Service Ligense 22. Name and Address of Facility Peaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine Due to (or as a consequence of, Cause (Disease or linjury the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): neral Director: After this certificate has been signed by the attending physician filled in by the funeral director, page 2 should be detached for use as the burial Certificate: To Be Completed by Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation after death Director: / 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause SARBARA CARROL of death (Item 23a) (Type, ARROLL RD., COCKEYSVILLE,MD 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

J. 45.PM

13/11

Kant NAS

ALEXANDER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36548 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ovember 9, Leon Key Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) City, Town, or Location of Death Examiner Baltimore MRULENS Greneral If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 8. Date of Birth 7. Age (In yrs. last birthday) Funeral Hours 08-16-35 76 216-32-3691 Director 1 🕱 M 2 🗆 F Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director items 23a or 28a-f s ner must be notified 1X Yes 2 ☐ No Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? #712 USA 1100 Pennsylvania Avenue Apt. 21201 death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?
Yes 2 No Black, White, etc. African ō, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: American "natural" 3 Widowed 4 Divorced Completed Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natul any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) The Baur School 12th Grade Assistant Teacher 4vrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Key Vines မ Noble Mae Emma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,21201$ 19a. Informant's Name/Relationship (Type, Print) 1100 Pennsylvania Avenue Apt.#712 Balto;MD Kathryne Key-Wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 11-21-11 | Owings Mills, MD Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service Licenses 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that dised the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ Commany disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Drabete Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buris Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Vear Day Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy has performed? Yes 2 No 1 ☐ Yes 2 ☑ No within 24 hours after death.

To the Funeral Director, After this certificate be completely filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 Inpatient 2 K ER/Outpatient 3 IDOA ျှ funeral (28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) MID 31464 4/10111 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 821 N. Eutan St Ente 308 BALTMORE MD 2126) MD HATHMI State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November nouse 0015 AM Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Count lembe 13-Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** If Under 24 Hrs Days Hours 041-30-0856 **Director** 1 K M 2 | F August 3,1937 Connecticut 74 show 10b. County 10c. City, Town or Location 10d. Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** Howard or 28a-f Maryland Dayton 1 🗌 Yes 2 🏝 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 21036 U.S.A. 4249 Linthicum Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces' Black, White, etc. or Completed by 1 Never Married 2 Married 1 X Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: "natural", 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Ma-Com Electrical Engineer and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Barbara Christ Lucius Knouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is 4249 Linthicum Road Dayton, Maryland 21036 Doris Knouse (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State . Page 1 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Atlantic Crematory Glen Burnie, Maryland 11-11-2011 any inj once. Signal e of uneral Service mense Witzke Funeral Homes, Inc. 22. Name and Address of Facility 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each ling. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ reumonia disease or condition Medical resulting in death) **Examiner** Sequentially list conditions Completed by Physician/Medical Examiner if any leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23h. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 1 ☐ Yes 2 № 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 🗷 No Other ျှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? Certificate: 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 2 Accider 5 Pending in 24 hours after deam.
The Funeral Director: Aft 2 🗌 No Accident 1 Yes Investigation Suicide 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined 29a. Certifier 1🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F only one) Colinber 21044 address of person who completed cause of death (Item 23a) (Type, Print)

State

Registra NOV 1

31. Date filed (Month, Day, Year)

Ky Suite 202

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 20 36550 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Nov 9, 2011 Year Belva Mae Krauss 7:20 P M Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Columbia Howard Gilchrist Howard County 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Days 1 🗆 M 2 🔀 F Months Hours 218-26-6543 81 Yrs Feb 21, 1930 MD Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director MD **Ellicott City** Howard 1 Yes 2 V No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 4921 Orchard Dr. 21043 U.S.A. within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 🛛 No Specify: Specify. 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give king or work – life, DO NOT use retired)

Cafeteria cashier (Give kind of work done during most of working filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic eveni 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Sterling Howard Downey Lena Mae vittkowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jerome S. Krauss spouse 4921 Orchard Dr. Ellicott City, MD 21043 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State metery, crematory or other place)
Atlantic Crematory, LLC 1 Burial 2 X Cremation 3 Removal from State Nov 14, 2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Part 1. Soter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ NON-HODGKINS B.CE-LL disease or condition 2008 Medical resulting in death) Due to (or as a cons uence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami Due to (or as a consequence of): resulting in death) Last physician a the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Pregnant at time of death signed by the a g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð CORUNARY ARTERY DISCASE Division of Vital Records, 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed ISCHEMIC CARDIOMYOPATHY 24a. Was an Were autopsy findings available prior to completion of cause of autopsy page death? 1 🗌 Yes 2 🗌 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 4 \square Nursing Home 5 \square Residence 6 \nearrow Other (Specify) 1 Tyes 2 X No မြ 1 Inpatient 2 ER/Outpatient 3 DOA HOSPICE 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury 1 Yes 2 No Accident Suicide Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🔲 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 264395 NOVEMBER 9, 2011 Z 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MD 21044 DANIEUE DOBERMAN, MS

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year

NOV 1 6 2011

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Donald Logan Lomax November 2011 08:50 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1612 Calvery Road Harford Bel Air 9. Birthplace (State or Foreign Country Philadelphia 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Yea 76 Yrs. Months Days Hours Min. 145-28-2663 1934 **Director** Dec. Pennsylvania Usual Residence of Decedent or 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at. Director 1 ☐ Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 1612 Calvery Road 21015 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

X Yes 2 \(\sum \) No 1957-Black, White, etc. þ 1 Never Married 2 X Married Maryland 21215-0036 If Yes, Give Year or Dates 1959 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 - Widowed 4 - Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Stockbroker Elementary/Seconday (0-12) College (1-4 or 5+) Stocks & Trade Resident VP of Legg Mason Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth Brumbach Joseph Lamax permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1612 Calvery Road, Bel Air, Maryland 21015 Mrs. Margarget Lorax (Spouse) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place Evans Funeral Chapel & Cramation Services 1 Burial 2 X Cremation 3 Removal from State November 15, Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Funeral Service Licensee Jeffrey R. Evans Funeral Chapel & Cremation Services - Bel Air Testeman (M01543) 3 Newport Drive, Forest Hill, Maryland 21050 23a. Par Error he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final 2057ATT CALCIEN Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year Pregnant at time of death 2 No a | Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 🖳 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 Yes 2. No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Desidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Hatural 2 Accident 3 Suicide 5 Pending injury 1 Yes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title

PHYSTUTAN

2510

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PHELEPLEUATIUNIN

29d. Date signed (Month. Day, Year)

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COPERCHTISAPANT DREWT, PIECKEL PDZIUN

Registrar DHMH 17 Rev 06-2011

State

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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TRACIE MORGAN, CRNP

31. Date filed (Month, Day, Year)

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4b. City, Town, or Location of Deat Randallstown 4a. Facility Name (if not institution, give street and number **Examiner** Baittimore Season's Hospice If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 088-36-4917 Days Hours Min 02/01/1948 63 **Director** 1 M 2 X F or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c, City, Town or Location 10d. Inside City Limits Director Riverdale MD Anne Arundel 1 X Yes 2 No 10e. Street and Number 67th Court 10f. Zip Code 7 ō 10g. Citizen of What Country? "natural", or items 23a o edical Examiner must be Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📈 No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify Black 1 ☐ Yes 2 ☐ No Specify Completed 3 X Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) 5+ Nurse Healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William McKinley Bernice Evans 19a. Informant's Name/Relationship (*Type, Print*) Erik S. Lymus / Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7829 Quill Point Drive, Bowie, MD 20728 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory 11/15/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services
PO Box 1413, Baltimore, MD 21203 Maishor 28e Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_{sician/} disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ulle to (or as a consequence of). Cause (Disease or injury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and I for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 month Month Pregnant at time of death Day signed by the at Id be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 3 Probably 4 Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv After this certificate 1 Tes Yes 25. Was case referred to edical To Be 26. Place of Death (Check only one) examiner? 1 Inpatient 2 ER/Outpatient 3 DOA funeral Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred latural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature ar 29c. License number on who completed cause of death (Item 23a) (Type, Print) State NOV 6 Registrar

ORIGINAL

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 36554 Certificate of Death 2. Dete of Death Month **Physician** hi 04 2011 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Manor Care Nursing Home Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral ½**M 2□ F Months Days 70 577-66-0195 unkn. Yrs Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours efter death with the Meryland 10a. Stete 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f ahor the Medical Examiner open be notified at Baltimore 1 XYes 2 ☐ No MD Director 10f. Zip Code 21234 10g. Citizen of What Country? 10e. Street end Number Cavalcade Court, Apt.E USA Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Asian Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) marked other than permit. Peges 1 end 2 should be filed with Depertment of Health end Mental Hygiene. Hospitality Chef 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be Yeung Yee Mui Henry Hing Lau ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2 Cavalcade Court, Apt. E., Baltimore, MD 21234 19a. Informant's Name/Relationship (Type, Print) Phillip Lau / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/10/2011 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee Dorota Marshall 22. Name and Address of Facility
Maryland Cremation Services PO box 1413, Baltimore, MD 21203 23e. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examine The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23b. Did tobacco use contribute to the csuse of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. ed by the e 3 □ Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? ZINO 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) P 1 Yes 25 No this funerel 28b. Time of 28d. Describe how injury occurred 27. Menner of Death Certification: eral Director: After I filled in by the funer Hospital or Attending Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No deeth. 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours e To the Funeral Completely filled Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Brint)

Registrar DHMH 16 Rev 6/95

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Mary Catherine Lego 2011 7:15pmNovember 14 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Good Shepherd Way at Carroll Lutheran 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Carroll Westminster
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Nov. 20, 1 Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🙀 F Months 89 Director 218-16-2367 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r 28a-f shov notified at 1 XYes 2 No Funeral Director MD Carroll Westminster 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or Items 23a or edical Examiner must be 205 St. Mark Way Apt. 403 21158 <u>USA</u> 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 😿 No If Yes, Give X Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Registered Nurse 7 is marked other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William H. O'Brien ပ Margaret C. Weller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau Mr. Arthur Burkett Lego (Spouse) 205 St. Mark Way Apt. 403, Westminster MD 21158 of Disposition (Name of Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lake View Memorial Park 11/18/2011 Sykesyille, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service License PO Box 195 Sykesvill, e MD 21784 23a. Part1. Enter the disease, or complications that cause of the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 1902TK /Medical consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a pursequence of Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, physician ar Due to (or as a consequence of) Physician/Medical attending for use as as IF FEMALE: nse If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 more 1 ☐ Yes 2 No 9 ☐ Unknown Month Day been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an autopsy 1☐ Yes 25. Was case referred to edical 26. Place of Death (Check only one) Medical Certification: To Be examiner? Other: 1 ☐ Yes 210 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) Injury 1 Matural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide I 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date sigged (Month, Day, Year) me and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

6 2011

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene, 36557 Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Vear 30 A 4 **Physician** 1-lora Lev 14 1.1 /Medical 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pikesville Baltimore Health Center Oaks If Under 1 Year
Months Days If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days 1 □ M 2 🗓 F Director 101-14-6010 95 03/25/1916 GERMANY Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director MD BALTIMORE PIKESVILLE 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 725 MT. WILSON LANE 21208 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: WHITE Completed by Specify. 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 BOOKKEEPER 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be HEINRICH LEVI CILA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) MARK LEVI / NEPHEW 15 BUCKS WAY ROAD OWINGS MILLS, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State CHEVRA AHAVAS CHESED 4 ☐ Donation 5 ☐ Other (Specify) 11/15/11 RANDALLSTOWN, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cadse on each line. Approximate Interval Between Onset end Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner anding physicien end use as the burial-transit Attending Physician: The law raquires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Due/to (or es e consequence of) Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No been signed should be d þ Completed 24a. Wes en autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t director, page 2 s T Yes ZLINU 1 ☐ Yes 2 ☐ No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 27 No Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 ER/Outpatient 3 DOA this s funerei 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred After 5 Pending aftar deeth. м 1 Yes 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) à 4 Homicide 6 within 24 hours a
To the Funerel C Hospital filled 29a. Cartifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.
2 He dical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. edical (Check only one) 3 CRNP the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number sens DV 30. Name end address of person who completed 8 Elsensta CR 32. Registrars Signature 31. Date filed (Month, Day, Year) State NOV 1 6 2011 Registrar

Pathent Known as Sarah, Levin

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			State of Maryland / Department of Health and Mental Hygiene Certificate of Death Certificate of Death Res No. 2011 36558											
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Division	or Atter fiter de virecto in by ti	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could not determined	28e. Place of In building, et	c. (Specify	(1)			Centre	City or To	wn. State)		MD 21268
Δ	To the Hospital or Attending Physician: The la within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ical (29a. Certifier	1 Certifying Ph	Courtland	f my know	ledge death	occurred	at the time	e, date and place,	and due to the	cause(s) ar	nd manner as s	Balhmore stated.
	he Hos in 24 h he Fur spletely	Medical	(Check	2 Medical Exam	niner: On the basis of or rse Practitioner: To the	examinatio	n and/or inves	stigation, i	n my opini	on, death occurred	at the time, date	and place,	, and due to the	cause(s) and manner stated.
	To the within 2 To the comple		29b. Signature and	title of certifier	1.)	2	2	9c. Licens	e number	γ	29d. Dat	e signed (Mon	
			30 Nama and add	ress of person who	completed cause of	death (Iten	n 23a) (Type	Priet(7)	, 1 (107)		Lps	Venco	LUVE . 2.2011
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Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ McClaine Jamys 10344 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Clinton PG 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral 7. Age (In vrs. last birthday) Davs Hours Director 01/27/1933 577-44-8574 1**√** M 2 □ F 78 Washington, DC show 10d. Inside City Limits death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MD PG Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 10224 Everley Terrace 20706 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? 1% Yes 2 No If Yes, Give 53–56 Year or Date 53 1 Never Married 2 X Married filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 - Widowed 4 - Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry al Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) years Senior Printer Covernment Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) item 27 is marked ၉ Hylan G. McClaine Bertha Strange 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Thomas McClaine (Wife) 10224 Everley Terrace; Lanham, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any injury or o once, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veteran Cemetery 11/21/2011 | Cheltenham, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Freeman Funeral Services 21. Signature of Tuner 4594 Beech Road; Temple Hills, MD Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. 23a, Part 1 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph sician/ MYCCOLIdian Interchion Phintos Medical resulting in death) Due to (or as a consequence of) Examiner Secondo Corcionimone Sequentially list conditions, if any saling control of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner a conse juence of the burial-transit Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the hur P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Tyes 2 🛂 No 1 Inpatient 2 FR/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 1 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie D0063207 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Read Surrate mo 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 36561 State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 2011 6:40 P.M Wilma Irene Miller November 14, Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Fun-eral Days June 4 287-20-5202 Director 1 M 2 V 86 Yrs. Ironton, Ohio 1925 death with the Maryland 10b County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director Timonium Baltimore Maryland 1 Tes 2XXNo 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States or items 23a Funeral 21093 11 Northwood Drive of America 11. Marital Status Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, injury or other traumatic event, the Medical Examiner. Armed Force Black, White, etc. þ 1 Never Married 2 Married Yes 2 No 3altimore, Maryland 21215-0036 white 1 Yes 2 No Specify: "natural", Yes. Give 3 Widowed 4XXDivorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) CSX 12 Accounting Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Flora Marie Hess George H. Gilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 11 Northwood Drive Timonium, Maryland 21093 Mrs. Deborah Miller/ daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State November cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 17, 2011 Timonium, Maryland 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Center, P. A.
2325 York Road Timonium, Maryland 21093 21. Signature of Fune al Service Leense any art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ covers TOVS disease or condition Medical resulting in death) Due to or as a consequence of) Exam iner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No be detached for Year Month Day Pregnant at time of death 5 Other (specify) 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed this certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: မ 1 🗌 Yes 2 300 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpa 4 Nursing Home 5 Residence 6 Other (Specify) WSOUL Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 \square Pending 1 🗌 Yes 2 🗌 No Investigation 24 hours after deat Funeral Director: 3 Sulcide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier

State Registrar

DHMH 17 Rev 06-2011

rawlesst. Turson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 0530 M Month Physician/ 201 OA Medical 4b. City, Town, or Location of Death Annapolis 4c. County of Death Anne Arundel **Examiner** acility Name (if not institution Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 560-46-5030 **Funeral** 76 1 Z M 2 🗆 F **Director** DC 03/14/1935 or 28a-f show 10d. Inside City Limits 10a. 10c. City, Town or Location with the Maryland iral", or items 23a or 28a-f sho Examiner must be notified at Director Clements MD St. Mary's 1 Yes 2X No 10f. Zip Code 20624 10g. Citizen of What Country? 10e. Street and Number 23485 Budds Creek Road Funeral should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No Na V V If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify White "natural", 3 Widowed 4 Divorced Completed of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4 or 5+) Elementary/Secondary (0-12) Engineering Drafting Engineer 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Dalton Bryce Maynard, Sr. မှ Gonzales Catherine 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 537 Center Drive, Severna Park, MD 21146 19a. Informant's Name/Relationship (Type, Print) Page 1 and 2 sh ment of Health a tant: If Item 27 is Poore / Step-Daughter Sylvia 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or c Chesapeake Crematory 1 Burial 2 XCremation 3 Removal from State 11/16/2011 Beltsville, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Dorqta Marshall 22. Name and Address of Facility Maryland Cremation Services 21203 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph_sician/ (Osp irator disease or condition resulting in death) Medical Due to (or a a conseque, ce of): **Examiner** 5 NEUMONIA PIRATION Sequer tielly list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) Pregnant at time of death 4 Pregnant a
9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy has perform after death.

I Director: After this certificate! Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 1 🗌 Yes 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending 2 Accident
3 Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 29d. Date signed (Month, Day, Year) 29c. License number 1) 21438 ovember 092011 Name and address of person who completed cause of death (Item 23a) (Type, Print)

NICHAEL J. CA FENTY M 445 DEFENSE HWY ANNAPOLIS MD 21401 31. Date filed (MM) 16 2011 Registrar's Sign State Registrar

DHMH 17 Rev 06-2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36563 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death John Milev Maphis Month Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location, Examiner 10120 North 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 - F Months Hours Min 0371771932 Country) 79 DC Director Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Funeral Director Ocean City MD Worcester notified 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 21842 23a 10120 North Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. ed Forces? (Yes 2 \sum No Army Black, White, etc 1 Never Married 2 X Married 1 X Yes 2 No Army If Yes, Give Year or Dates. 1952-56 ö þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 Widowed 4 Divorced "natural" Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Insurance other of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Luther Maphis Ursula Beall 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10120 North Ave., Ocean City, MD 21842 Deborah S. Maphis / Spouse Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory 20c. Location - City or Town, State Date 1 Burial 2XX Cremation 3 Removal from State 11/14/2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) PO Box 1413, Baltimore, MD 2103 Signature of Funeral Service Licensee Donota Marshall 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause Enter Charles Physician/Medical Examine Due to (or as a consequence of) Cause (Disease or iinjury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician I for use as the burial Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Other (specify) Pregnant at time of death signed by the at I be detached fo Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy has page 2 24 hours after death. Funeral Director: After this certificate 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: ျှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 7. Manner of Death 28c. Injury at work?
1 Yes 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending 2 No Investigation Accident filled in by the 6 🗌 Suicide Could not be Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

ASTEKN STAKE DK, SALISBURY MD 21804

ause of death (Item 23a) (Type, Print)

Registrar's Signat

James Ellwood Meadows, Jr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 36564

		1- For State Certificate Registrar	ate of Death	Reg. N							
Physic Physical Exam	ian/ iner	1. Decedent's Name (First, Middle,Last) James Ellwood Meadows, Jr.		Date of Death Month Da November 12	v Year	3. Time of Death 1622 hrs					
		4a. Facility Name (if not institution, give street and number) 805 Creek Road	4b. City, Town, or Location of Death Essex	n	4c. County of Death Baltimore County						
Funera Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt 214 78 7606 1\overline{X}_M 2_F 53	hday) If Under 1 Year If Under 24Hr Months Days Hours Mir Yrs.		MM/DD/YYYY) 9. Birthplace (State or Foreign Maryla: Country)						
ow any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Maryland Baltimore Essex									
with the Maryland ns 23a or 28a-f show be notified at once.	Director	10e. Street and Number 805 Creek Rd.	10f. Zip Code 21221	10g. (Citizen of What Count USA	1 Yes 2 No					
hours after death with the Maryland natural", or items 23a or 28a-f sh Caminer must be notified at once	by Funeral C	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes, Give Year or Pates:	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto		14. Race - Americ White, etc. Specify: Whit						
2 3 =	Completed b	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use rel Disabled		b. Kind of Business/Ir	dustry					
		17. Father's Name (First, Middle, Last) James Ellwood Meadows Sr.	18.Mother's Nam Edna Mae	e (First, Middle, Maid e Akers	en Surname)						
MD 21 12 should th and Me 1 27 is ma umatic ev	욘	Edna Mae Akers (Mother)	b. Mailing Address (Street and Number or 305 Creek Rd. Baltim	ore, Maryl	Land 21221						
re I and free I and free I fre		1 Burial 2 Cremation 3 Removal from State Sacred			Baltimore,						
Physician		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryla 23a. Part I. Enter the disease, or or plicat Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryla failure. List only one cause on each line.									
/Medica Examine			Alcohol Intoxication			Between Onset and Death					
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause									
recuted 1 and - transit	I Examiner			1 20 10	_						
a a a	Medical	x UNPENDED AMENDED 23a, pt.II, 2	27,28a-f,per me,g923								
Box 68760, e death certificate be the attending physic ed for use as the bur	ician/		Fetal death 3 Ectopic pregn Other (Specify)		23d. Date of delivery Month D	ay Year					
P.O. B. es that the de igned by the de detached f					co use contribute to t						
ords, P w requires the specific specific specific specific should be d	eted b	Hypertensive Atherosclerotic Car Cirrhosis of the liver, Chronic O		1 24a Mas an		opsy findings available ompletion of cause of					
of Vital Records, ng Physician: The law require ther this certificate has been si meral director, page 2 should b	Completed by	Disease		1 ✓ Yes 2		_					
ician:	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/O	26 Place of Death (Check utpatient 3 DOA Other Nursi		sidence 6 🗸 Other:	Scene					
ing Physi After this		1 Yes 2 No	Time of Injury 28c. Injury at Work?	28d. Describe how	injury occurred						
ision Attendin r death. rector: A	atio	Natural 5 Pending Fd 11-12-11 fd	4:10 pm 1 Yes 2 X No	subject t	ook drug	and alcohol					
Division of Vital Records, P.O. Box 68: the Bospital or Attending Physician: The law requires that the death certificate the thours after death. The law requires that the death conficue has been signed by the standing the Funeral Director. After this certificate has been signed by the standing inheley filled in by the funeral director, page 2 should be detached for use as:	Certification		arm, street, factory, office building, etc.	28f. Location (Street or Town, State Essex, Md.	805 Creek	ral Route Number, City Rd •					
To the Host within 24 ho	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, decode one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ath occurred at the time, date and place, an investigation, in my opinion, death occurred	d due to the cause(s) at the time, date and	and manner as state place, and due to the	ed. e cause(s)					
F. Witing	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		od. Date signed (Mon lovember 13, 20						
send		30. Name and address of person who completed cause of death (Item 23a)									
1	State	24 Date Standard at the Country of Standard Standard	900 W. Baltimore Street, Balti	more, MD 2122	J						
Regi			alle								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36565 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November Physician/ Vera Joan Maguire 2011 10:10 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Stella Maris Timonium Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth **Funeral** Age (In yrs. last birthday) Days Min **1**59-18-7994 97 Director 1 🗆 M 2 🕱 F August 3, 1914 Pennsylvania 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Meckal Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location Director 1 🗌 Yes 2 🔀 No MD. Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21239 USA 1304 Glendale Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 🛚 Widowed 4 🗆 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) U.S. Government Office Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NOVEMBER 12, 2011 ပ Joseph E. Cavanaugh Vera L. Ryan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1304 Glendale Rd. Baltimore, MD. 21239 Maureen Maguire/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Conshohocken, PA. Calvary Cemetery 11-17-11 4 ☐ Donation 5 ☐ Other (Specify) 22. NamRaid Rod Tow Solly Funeral Home, 21. Signature of peral Service Licensee 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ GASTROINTESTINAL BLEED disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): igned by the attending physician and be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 X No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown VERA MARUIRE signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has k autopsy performed? Yes 2 🔽 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 T Other (Specify) HOSPICE Hospital 2 1 Tes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: X Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Day, Year) 29c. License number 30. Name and address of person who complete cause of death (Item 23a) (Type, Print) U TIMONIUM, MD 21093 TRACIE MORGAN, CRNP 2300 DULANEY VALLEY RD.

DHMH 17 Rev 06-2011

State

Registrar

Date filed (Month, Day, Year)

NOV 1 6 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Physician/ Mattingly Thomas W. November 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Greater Baltimore Medical Cent 8. Date of Birth If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** ^{Year)}1930 1**X**□ M 2 □ F Days Hours Mary land 81 **Director** 214-24-8288 July Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2X No Lutherville MD. Baltimore 10f. Zip Code 10g. Citizen of What Country? ō 10e. Street and Numbe Funeral items 23a USA 21093 114 Felton Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. o, 1 Never Married 2X Married by Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X☐ No Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than aumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Contractor Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Howard Τ. Mattingly Shepp Lorene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trau once. 114 Felton Rd. Lutherville, MD. 21093 Jane C. Mattingly/ Wife timore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛣 Cremation 3 🗀 Removal from State cemetery, crematory or other place, Hilltop Service Co. 11-16-11 Towson, MD. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. Ineral Service Licensee Bai 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ seotic Shock disease or condition resulting in death)) Medical or as a consequence of) **Examiner** anemin Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events colon cancer Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Month Year 5 Other (specify) Pregnant at time of death signed by the a d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ No 3 Probably 4 Unknown 1 Yes Completed page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3 IDOA After this 28a. Date of injury (Month, Day, Year) Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work?
1 Yes 2 No Accident Investigation filled in by the within 24 hours after deat To the Funeral Director; Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🗶 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) d title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 29b. Signature a

State Registrar 31. Date filed (Month, Day, Year)

NOV 1 6 2011

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Charles

Towson mi)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36567 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Physician/ Month Margaret Marshall Mitchell 4:00 A^{M} Nov. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Hospice Care Towson If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign Funeral Days Min (Month, Day, Year) 218-30-6253 Director 1 **X**M 2 □ F 77 Oct. 25. 1934 | Maryland Usual Residence of Decedent or 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Baltimore 1 Yes 2XXNo Md. Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1055 W. Joppa Rd. Apt. 747 21204 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 Never Married 2 Married þ Yes, Give Baltimore, Maryland 21215-0036 hours after 1 Yes 2 No Specify Specify: 3 Widowed 4 Divorced White Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) 72 than, Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William Harlan Taylor Maxine Schroeder Regina injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Braxton D. Mitchell, Sr./Husband 1055 W. Joppa Rd. Apt.747 Towson, Maryland 21204 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11/16/11 Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Funeral Service Lic 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, of omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical hoelcystitis Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last physician s the burial buria Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No for Month Day Year Pregnant at time of death ed by the a detached 9 Unknown 9 Unknown signed by t. Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law this certificate has page 2 performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: No No 1 Yes 2 ER/Outpatient 3 DOA 6 Other (Specify) 1 Inpatient 2 I 4 Nursing Home 5 Residence To the Hospital Community 24 hours after death.
To the Funeral Director: After this commoletely filled in by the funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signaty itle of certifie address of person who completed cause of death (Item 23a) (Type, Print HAVES M6101 31. Date filed (Month, Day, Year, State NOV 1 6 2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36568 Certificate of Death 3. Time of Death 2. Date of Death ent's Name (First, Middle, Last) Physician/ Medical Name (if not institution, give street and 4b. City, Town, or Location of 4c. County of Death **Examiner** NASh SIEN If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 🗆 F 53 Months Days Hours Min. Country) NM **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director Anne Arundel MD 1 ☐ Yes 2 X No Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21061 USA Funeral 1420 Crain Hwy South apt 10 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black White etc. β 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Widowed 4 X Divorced Medical Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Maximone. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Eugene Mishler Lillian Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1188 Borgstrom Ave Ypsilanti MI 48198 Kyle D. Mishler Son 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date Atlantic Crem 1 Burial 2 X Cremation 3 Removal from State 11/9/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequence of Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Due to for as a soriesqueries of, as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autops page 2 certificate 1 Yes 2 No Yes funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗌 No Other: ပ ER/Outpatient 3 DOA 1 Inpatient 2 4 Nursing Home 5 Residence 6 Other (Specify, this Manner of Death Date of injury (Month, Day, Year) 1 Natural 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No injury 5 Pending s after death. Accident Investigation completed filled in by the Suicide 6 Could not be 3 ∐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Leading Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best 29b. Signature and title of certifier use of death (Item 23a) (Type, Print) 095 America

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who complete

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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fildred Robinet		1- For State	f Maryland / Departm Ce <i>rtific</i>	ent of Health an ate of Death	nd Mental H		No 201	1 3656	
Physici Physici Exami	an/	Registrar 1. Decedent's Name (First, Middle,Last) Robinette Mild*			2. Date of Death Month I November 5	, 110.	3. Time of Death 2236 hrs		
		4a. Facility Name (if not institution, give st 2038 Littlestown Pike	reet and number) 4b. City, Town, or Location of Death Westminster						
Funeral Director		5. Social Security Number 217-62-7508 6. Sex	7. Age (In yrs. last birt	thday) If Under 1 Yea Months Day			Foreig	thplace (State or gn puntry) MD	
Aaryland 28a-f show any Lat once.	tor	Usual Residence of Decedent 10a. State 10b. County MD Carroll 10e. Street and Number	10c. City, Town W∈	estminster		1100	g. Citizen of What Cour	10d. Inside City Limits 1 Yes 2 No	
eath with the Maryland items 23a or 28a-f sho ust be notified at once.	al Director	2038 Littlestow		10f. Zip Code 2115			USA	-	
	by Funeral	1 Never Married 2 Married 1 3 Widowed 4 Divorced If or	r Dates:	13. Was Decedent of Hi If Yes, specify Cubar 1 Yes 2 No	n, Mexican, Puerto o <i>specify:</i>	Rican, etc.)	White, etc. Specify: Wh	ican Indian, Black,	
21215-0036 Id be filed within 72 hours after d dental Hygiene. narked nther than "natural", nr event, the Medical Examiner m	mpleted	15. Decedent's Education (Specify only I Elementary/Secondary (0-12) 12yrs	College (1-4 or 5+)	Decedent's Usual Occupa during most of working life rinter Tec	e. DO NOT use reti				
21215-0036 uld be filed within 7 Mental Hygiene. marked rither than	Be	17. Father's Name (First, Middle, Last) Edward Brown			Zachman	(First, Middle, Maiden Surname) Zachman			
MD 21 Id 2 should olth and Me m 27 is ma		19a Informant's Name/Relationship (Type Melissa Parker	Daughter 6	b. Mailing Address (Stree 600 Millwr	ight Ct	Apt 22	Millers	ville MD	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked nither thingury nr other traumante event, the Mediany or other traumante.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:	Removal from State Attan	of Disposition (Name of ce ory or other place) TIC CIEM	11/	9/11	20c. Location - City or Glen Bur	nie MD	
Balti permit. Departr Import injury		21. Superior of Funeral Service Licensee	h	ThomasAl	lenPA 7	090 Rid	Crem & lge Rd Ha	nover MD	
Physician /Medicar Examiner	ı		ations that caused the death. Do no line. Methadone Int f the liver	t enter the mode of dying toxication of	n, such as cardiac o complicat	r respiratory arrest ed by Ci	t, shock, or heart rrhosis	Approximate Interval Between Onset and Death	
- Aramme		Sequentially list conditions, b	e to (or as a consequence of):						
X _ =	Examiner	cause. Enter Underlying Cause	e to (or as a consequence of):						
oe executed cian and nrial - transit	dical	d. X UNPENDED A G	AMENDED Item 1 as n	oted,23a,pt	.11,27,28	a-f,per	me 1-9-12		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the bur	울	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Pregnant at time of death 9 Unknown		ancy	23d. Date of delivery Month E	y Day Year		
i, P.O. E	ρ	Part II. Other significant conditions con Hypertensive Card:	And the second s						
Division of Vital Records, talor Attending Physician: The law requir rs after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed	Chronic Alcoholis				utopsy findings available completion of cause of			
certific	BeC	25. Was case referred to medical examiner?	pital: 1 Inpatient 2 FR/O	26,Place	e of Death (Check				
Physic Physic er this	P	1 ✓ Yes 2 No 27. Manner of Death		utpatient 3 DOA Time of Injury 28c. Inju	Ury at Work?		esidence 6 🗹 Other	r; Scene	
Sion O Attending r death. ector: Aft by the fune	Certification:	1 Natural 5 Pending 2 X Accident Investigation	(Month, Day, Year) fd 11-5-11 fd	10:26 pm ¹□	28d. Describe how injury occurred subject ingested drug				
28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Town, State) 2038 L 28f. Location (Street and Number or Town, State) 2038 L (Specify) Found at Residence							te)2038 Litt	lestown Pike	
Tn the Hosp within 24 hos To the Fune completely fi	Medical C	29a. Certifier 1 Certifying Physician: (Check only one) 2 Medical Examiner: On	To the best of my knowledge, dean the basic of examination and/or in manner stated.	ath occurred at the time, d	date and place, and n, death occurred a	I due to the cause(s) and manner as state	ed.	
	We	29b. Signature and title of certifier	S-11801 (F) Ctu100.	29c. Licens O.C.			29d. Date signed <i>(Mor</i> November 6, 201		
OGME		30. Name and address of person who com Mary G. Ripple MD. Deput	npleted cause of death (Item 23a) ty Chief Medical Examiner	900 W. Baltimore	e Street, Baltir	nore, MD 212	23		
S	ate	31. Date filed (Month, Day, Year)	32. R gistrar's Signature	-	-				

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36570 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ **Evelyn Louise Marquess** 2011 0555PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** BALTIMORE MD SAINT AGNES HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Davs Hours Min. (Month, Day, Year) Aug 19, 1930 Country) 1 □ M 2 🕱 F MD 217-26-3452 81 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Catonsville or 28a-f MD **Baltimore** 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 21228 2528 Old Frederick Rd. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2 X No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Textiles** and Mental Hygiene. **Textile Mill** is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Eleanora Lavina Foster Willis Fowble Sterner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trau 504 Owings Ave. Reisterstown, MD 21136 Susan Schultz Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place)

Good Shepherd Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State Nov 05, 2011 Ellicott City, Maryland 5 Other (Specify) Donation 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 ignature of uneral Service Lice mellell MOOSES 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ OBSTRUCTIVE PULMONARY 415 CHRONIC disease or condition res ting in death) Medical Due to (or as a consequence of): **Examiner** MONITH CONGESTIVE HEART Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine physician and the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by ACUTE RENAL FAILURE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be 4 Homicide determined

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 n 24 hours and he Funeral Director: Aff

28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

Sundruga

SINDHUJA

NOVEMBER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARUPUDI

AVENUE MD 21229 BALTIMORE

State Registrar

Medical

31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 6 2011

within 2

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Physician/ Elva Gertrude McCauley 748 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** 5+ BALTIMORE HOSPITAL NGNES 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 6 Sex . Age (In vrs. last birthday) **Funeral** (Month, Day, Year) May 10, 1918 Months Days Hours 1 M 2 X F 220-24-2628 93 Director Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director Catonsville **Baltimore** 1 Yes 2 XNo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe U.S.A. Funeral 21228 904 Sedgley Road . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces Black, White, etc. Yes 2 No Yes, Give þ 1 Never Married 2 Married Maryland 21215-0036 White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales Clerk Bakery IINKMUN Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last Esther Ledna Green ပ Wilbur Nelson Wiles 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 904 Sedgley Road Catonsville, MD 21228 **Evelyn Fox** Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Nov 11, 2011 Ellicott City, Maryland **Good Shepherd Cemetery** Donation 5 Other (Specify 22. Name and Address of Facility Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 21. Si ture of Funeral Service 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Inset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): the burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last nding physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 use as IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy atter in the past 12 months?

1 Yes 2 No Month Dav jo Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 🗗 Unknown 1 Yes 2 No 3 Probably Division of Vital Records, Completed been si 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has page 2 autopsy performed 2 🗌 No certificate 1 Tyes Yes 26. Place of Death (Check only one) completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be examiner? Hospital 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 Tyes 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Mann of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at s after death. I Director: After the work? 1 Yes 2 No iniury 5 Pending Natural Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖟 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

State Registrar

29b. Signature and title of certifie

1 6 2011 32. Registrar's Sign:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HMH 17 Rev 7/2009

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 4b, per phy, g921 11-16-11 sm
State of Maryland / Department of Health and Mental Hygiene 36572 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle, Last) Physician/ NOVEMBER 2011 06:40 PM MERKIN MORRIS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number)

Northwest

SEASONS HOSPICE AT NORTH WEST HOSP. City, Town, or Location of Death Randallstown Examiner BALTIMORE If Under If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthdav Social Security Number 6. Sex **Funeral** (Month, Dav. Year) Days Hours Min 093-16-8265 Director 1 🛛 M 2 🗆 F 90 Yrs. CHINA 02/12/1921 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10h County be notified at Director 1 ☐ Yes 2 X No PALM BEACH BOCA RATON FL10g. Citizen of What Country? or 2 10e. Street and Number 10f. Zip Code 23a Funeral must I USA 1021 WOLVERTON B 33434 or items 12. Was Decedent Ever in U.S. Armed Forces2
1 ☐ Yes 2 ⚠ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Examiner Black White etc þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: WHITE "natural". 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 7 th and Mental Hygiene. other than College (1-4 or 5+) 4 YEARS Elementary/Secondary (0-12) other traumatic event, the INSURANCE SALESMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည COHEN MERKIN **PESSYA** ARYAH LEIB 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health i 3309 BONNIE ROAD, BALTIMORE, MD 21208 SURI RIFKIND/DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of Important; If it any injury or o To cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State PINELAWN, NY WELLWOOD CEMETERY 11/14/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, BALTIMORE, MD 21208 1ass 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HERRI PAILURE 2 Mest TIFS Sequentially list conditions, Examine cause. Enter Underlying
Cause (Disease or injury ATHEROSCIENOTIC CAHINO WAS WHAT dis Egge transit and that initiated events Due to (or as a consequence o resulting in death) Last physician ar s the burial-t Physician/Medical requires that the death certificate be Box 68760 as 1 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Year ĺ Month Pregnant at time of death 9 Unknown 9 Unknown signed by ti P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Records, Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician: The law) Nospire. -.
, 24 hours after death.
e Funeral Director. After this certificate has the there is the funeral director, page 2. autopsy perform 1 Yes 2 No 1 Tes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 မြ 1 Yes Mnpatient 2 ☐ ER/Outpatient 3 ☐ DCA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Deat 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending work?
1 Yes injury Vatural 5 Pending 2 🗌 No Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License numbe 13/1/ 025039 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 2835

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 36573 For State Registrar Certificate of Death 1. Deceder t's Name (First, Middle, Last) 2. Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Windsor Mill Northwest Hospital 5. Social Security Number 218-26-7271 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In vrs. last birthday) Hours Director 1 M 2 X F 05/27/1930 81 Maryland Usual Residence of Decedent show ms 23a or 28a-f sho must be notified at 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Pikesville MD Baltimore Co. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4627 Breckenridge Lane 21208 U.S.A. Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items "natural", or item edical Examiner n Was Decedent Ever in U.S . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces þ 1 Never Married 2 Married ☐ Yes Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: Black 3 X Widowed 4 ☐ Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) 12th Grade College (1-4 or 5+) Self Domestic Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Lloyd Bell Myrtle Dunton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4627 Breckenridge Ln., Pikesville, MD 21208 JoAnn Breckenridge(niece) other 1 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State on-site Crematory 11/15/11 Baltimore, MD 5 Other (Specify) 4 Donation eral Service Licensee 子のSephoth: of Brown Jr. Funeral Home 2140 N. Fulton Ave., Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each li the death. Do not enter the mode of dying, such a rardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions Examine if any, leading to immediate cause. Liner Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ ō in the past 12 months? Year Pregnant at time of death 1 Yes 2 No ed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Inknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has perform death? 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other 2/2010 မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After thi filled in by the funeral 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury death. 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 24 hours a Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature 29c. License number

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State Registrar 30 Name and a

son who completed cause of death (Item 23a) (Type, Pr

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEM? Medical Location of Death 4c. County of Death **Examiner** lf Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** M 2 □ F Months Hours Min **Director** Usual Residence of Decedent show 10a. State 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked of other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Ves 2 □ No 0 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ò 2 No Baltimore, Maryland 21215-0036 __ Yes If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education ify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) conday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street, and Number or Rural Route Number, City or Town, State, Zip Gode, lako Method of Disposition 20b. Place of Disposition Name of Mc. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State cemptery, crematy 4 Donation 5 Other (Specify) Signature of Funeral Service Livense En 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ ENUL -STAT disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and Exami Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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o the Funeral Director: Aft Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year)

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Name and address of person who completed cause of death (Item 23a) (Type, Print)

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700 W 40th STREET, BACTIMORE, MD 2R11

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pital o		29a. Certifier 1	Cortifuing 5	Physician: To the b	hast of my know	vledge death	occured at t	he time date an	nd place, ar	nd due to the ca	ause(s) a	nd manner as st	ated.	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2	Medical Ex	aminer: On the bas lurse Practioner:	sis of examination	on and/or invest	tigation, in n	y opinion, death	occurred a	t the time, date	and place	e, and due to the	cause(s) an	d manner stated.
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

29a. Certifier

only one) 29b. Signature and

title of certifier

APATHE KOMAR 31. Date filed (Month, Day, Year) NOV 1 6 2011

Director

Funeral

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For State Registrar		State of M		•		ate of L				Reg. No.	20	4	3657
. Decedent's Name		· ·							2. Date of Dea	ath	20	ear	3. Time of Death
William (1		Les		Novembe		201		4:42 PM
a. Facility Name (if r Gilchris		e street and number)				city, Town, or WSON	Location	∪ Death			County of Daltim		
Social Security Nu	umber 6. 5	Sex 7. Ag	ge (In yrs. la:	st birthday		nder 1 Year	If Under Hours	24 Hrs.	8. Date of Birt	th			lace (State or Foreign
024-03-84		1 X M 2 □ F	97	Yrs.	Mont	Days	. Iours		imonth, Day January		914		York
Usual Residence of Da. State	of Decedent 10b. County		10c. City	, Town or l	Location	1				-		10	Od. Inside City Limits
Maryland	Baltimo	re	Park	kvill	е								1 ☐ Yes 2 X No
e. Street and Num			-			Zip Code				_	zen of Wha		
820 Walt	her Blvd					1234					ed St		
Marital Status Never Marris	ad 2 🗆	12. Was Decedent Armed Forces?		. 13	B. Was De	cedent of Hi pecify Cuba	ispanic Ori n, Mexicar	igin? (Speci n, Puerto Ri	ify Yes or No- ican, etc.)		14. Race - A Black, V	America White, et	
1 ☐ Never Marrie 3 XX Widowed 4		1 ☐ Yes 2 X If Yes, Give Year or Dates.	i MO		1 🗌 Yes	s 2 🔀 No	Specify:				Specify: V		
(Spec	15. Decedent's l cify only highest g	Education		(Giv	e kind of	Jsual Occupa work done d	ation luring mos	t of working	7	16b. Kir	nd of Busin	ness/Ind	lustry
Elementary/Secon		College (1-4 or	5+)	life.	DO NOT	use retired) engir					q+	ee1	
7. Father's Name (F	First, Middle. Lasti	4		ııld	- 1116	-ugri		er's Name	(First, Middle,	Maiden S			
Edward Wh									. Bran	_			
9a. Informant's Nar	me/Relationship (Type, Print)			_		and Numbe	er or Rural I	Route Numbe	er, City or		e, Zip Co	ode)
		daughter/			_	od Rd.		ourne		0253			
Da. Method of Dispo		☐ Removal from State	ce		rematory o	or other plac	:e)	Da			cation - Cit		
	☐ Cremation 3 L 5 ☐ Other (Spec		2	Норе	Cem	etery	N		7,2011	7	mouth		A
1. Signature of Fund	a. mitt	Thell							uneral imore,		e In 2121	ig.	
shock, or heart	t failure. List only	nplications that cause one cause on each lin	d the death e.										Approximate Interval Between
mmediate Cause (F disease or condition	Final	a Meta	Luck	ر د	Pra	State	Co	unco	<u> </u>				Onset and Death
esulting in death)		Due to (or as	a conseque	ence of):									
Sequentially list con f any, leading to imi	nditions, mediate	b. Due to (or as	a consequ	ence of									
ause. Enter Underl Cause (Disease or in	rlying injury	240 (U) ds	ooqu	- VIJ.									
hat initiated events esulting in death) L		Due to (or as	a conseque	ence of):									
		d										\bot	
FEMALE:													
 FEMALE: 3b. Was decedent past 12 m 		23c. If yes, outcome	2 Fetal	I death 3		oic pregnanc	у			1 2	23d. Date o		•
1 Yes 2 9 Unknown		4 ☐ Pregnant : 9 ☐ Unknown				r (specify)					Month	•	Day Year
	icant conditions	contributing to death	out not resi	ulting in the	e underlyi	ng cause aiv	en in Part	l.	23e. Did to	obacco u	se contribu	ite to the	e cause of death?
g-IIII						3"							pably 4 Granknown
				_					24a. Was	an	24b. Wer	re autop	osv findings available
									autop	psy ormed?	prio dea	or to con ath?	mpletion of cause of
i. Was case referre	ed to medical					26 PI	ace of Dec	ath (Check o	1 \(\text{Yes}	2 N o	1 _	」 Yes	2 No
examiner?		Hospital:	tient 2 🗆 I	ER/Outnat	ient 3	Othe	0.41		ne 5 Resid	dence 6	Other (Specify	Haxbica
7. Manner of Death		28a. Date of inj	ury	28b. Time	of	28c. Injury	y at	$\overline{}$	8d. Describe h			, 2011Y)	
1 Natural	5 Pending	(Month, De	ıy, rear)	injury		work] NI.					
	5 Pending Investigation 6 Could not lightermined	be 280 Blood of In			М	1 🗆	Yes 2		04 1 "	Ctr- '	J N/*	v. D	Route Number,

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 the attending p ed by the a this certificate has page within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

> State Registrar

64

NCHARLES

MD

32. Registrar's signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

SULTE 4105

29d. Date signed (Month, Day, Year)

12

BALTIMORIZ

29c. License number

D71040

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 07:45 AM Physician 16 11 eronica /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore** Johns Hopkins Bayview Medical Center Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 6. Sex 7. Age (In yrs. last birthday) Social Security Number Hours **Funeral** 1 🗆 M 2 💢 F 214-62-868 MARY/mit **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show dical Examiner must be notified at Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number be filed within 72 hours after death with 2122 3865 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 No Specify Specify: Whit ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) 101 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 is marked other any injury or other traumatic. 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Maryland Be hristoph ပ္ 19b. Mailing Address (Street and Number or Rural oute Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MESOND 3805 on startine thray invis 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition
1 Burial 2 Cremation cemetery, crematory or other place) 3 Removal from State 17- 3011 5 Other (Specify) 4
Donation 21. Signature of Juneral Service Licenses 22. Name and Address of Facility S CONICIA omplications that caused the death. Do not enter the mode of dying, such as cardiae or respiratory arrest one cause on each line. Approximate Interval Between Onset and Death 23a. Fed . Enter the d shock, or hear far Immediate Cause (Final day Due to (fr as a consequence of): **Physician** disease or condition resulting in death) /Medical **Examiner** 9310+ic Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of, physician and is the burial-transit or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical as IF FEMALE: nse 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant Live birth 2 Fetal death 3 🗀 Ectopic pregnancy in the past 12 months? Month Day ed by the atten Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Qid tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò Division of Vital Records, 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate has b 2 □ No 1 Tyes 2 No 1 Tes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 2X No 1 Nnpatient 2 ER/Outpatient 3 🗌 DOA 1 🗌 Yes မ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: I Director: After to ad in by the funera 5 Pending investigation 2 🗌 No 1 TYes 2 Accident after death. 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (check only within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie VA 0101240243 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224

Registrar DHMH 17 Rev 1/2001

11595

State

SCHUENEMAN

32. Registrar's Signature

J.

Date filed (Month, Day, Year)

NOV 1 6 2011

AARON

Please Type of Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Farinholt O'Malley Elsie 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ **FARINHOLD** O'MALL EY November 14. 8:10A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Blakehurst Towson Social Security Numbe . Age (In vrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min 09/02/1916 ar) Virginia Director 213-10-3084 95 Usual Residence of Decedent show 10b. County be filed within 72 hours after death with the Maryland : If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at Director 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 XXNo Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 1055 West Joppa Road 21204 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2XX No Specify: White XX Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If tem 27 is marked other than any injury or other trainmets. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ John Leroy Farinhold Mary Daughtry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sheila O'Malley Bertoldi 12419 Falls Road Cockeysville, Maryland 21030 20a. Method of Disposition

1 → Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Dulaney Valley Memorial Grans 11/16/2011 Timonium, Maryland Donation 5 Other (Specify) nature of Funera 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complicat ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one Immediate Cause (Final Onset and Death Ph sician/ ere brovasular discase disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury that initiated experts) Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was a. autopsy performed? hast After this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) B examiner? Other: 1 \square Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a

To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) November 14 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chanles ST TOWSON 6701 MY Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER 11 20 lear 07:20A M OPPENHEIM STANLEY Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE 12240 ROUNDWOOD ROAD, #602 LUTHERVILLE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Age (In yrs. last birthday) Funeral Days Hours 04771471937 74 Yrs MD **Director** 216-32-6134 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 X No MD BALTIMORE LUTHERVILLE 10e. Street and Number 10f. Zip Code 10a, Citizen of What Country? Funeral USA 21093 12240 ROUNDWOOD ROAD, #602 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1

Yes 2

No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes. Give 3 Divorced 4 Divorced WHITE Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SAVAL FOODS SALES Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) မ KAHANOVSKY OPPENHEIM AMELIA GILBERT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LUTHERVILLE, MD 21093 12240 ROUNDWOOD ROAD, #602, DEBBIE OPPENHEIM/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place, OHEL YAKOV BETH ISRAEL CONG 20a, Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 11/14/2011 BALTIMORE, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. e of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or com Wations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securitally list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of for use as the burial-trans oronary that initiated events resulting in death) Last Due to (or as a conseduence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death been signed by the sales should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autops Yes 1 ☐ Yes 2 ☐ No certificate the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X10 ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident
Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

the Hospital or Attending Physician; The law requires that the death certificate be executed Stantey Countain 11 Division of Vital Records, P.O. Box 68760 within 24 hours after de To the Funeral Directo completed filled in by th

20am

120 State

Registrar

(Check

only one)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

th (Item 23a) (Type, Pript)

32. Registrar's Signature

Ecrtifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

11-08489 Lakei Player Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend # state of Mathian / Department of Health and Mental Hygiene

ei Player		amend in the state amend in the	State d	MMan∯i2		partinent ertificate			Menta	H Hy		Reg. No	20		36580
Physicia dical Exami	an/	1. Decedent's Name (First, Lakel Play		Lakeis	sha P	layer					Date of De Month Novemb	ath Dav	Year		Time of Death
		4a. Facility Name (if not inst 2612 Kentucky Av	_	street and nu	imber)		4b. City, To Baltim		ocation of I	Death		4	tc. County of	Death	N/A
Funeral Director		5. Social Security Number 214-08-563	2 6. Sex	1 2 X F	7. Age (In yrs	s. last birthday) 6	If Under Months	_	If Under 2 Hours	24Hrs. Min.	8. Date of E 2 /	Birth (MN	и/DD/YYYY) 85	9. Birthp Foreign Count	elace (State or tryMD
yland -f show any once.	tor	Usual Residence of Decede 10a. State 10b. Co MD			10c. C	ity, Town or Loc Balt	imore					10a C	itizen of Wha	1	Od. Inside City Limits
h the Mar 3a or 28a otified at	Director	10e. Street and Number 2612 Kentu	cky P	Ave			10f. Zip (120	6			-	USA		
STE, MD 21215-0036 St and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f showner frammatic event, the Medical Examiner must be notified at once.	by Funeral		Married Divorced	Armed For 1 Yes Yes, Give Yea or Dates:	2 🔀 No) 1	Vas Deceden Yes, specify Yes 2	Cuban, I	Mexican, P	uerto R	ican, etc.)		White, Afri Specify: A	etc. .can .mer	
5-0036 Iled within 72 hours Hygiene. Jother than "natur	Completed	15. Decedent's Education Elementary/Secondary (0 12	-12)	highest grad College (1		during	ent's Usual O most of work ursin	ing life. [g A	ss't	e retire	d)]	. Kind of Bus Nursi		
1215-0 be filed wental Hygical reference of the	Be Co	17. Father's Name (First, Mi Gary Playe	r						Shir	ley	Ann	Ca			
MD 21 d 2 should lih and Me n 27 is ma	To	19a. Informant's Name/Rela Patricia C				139	ng Address N.B	roa	dway	av	,Balt	.,1	MD 21	231	
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is ma injury or other traumatic er		4 Donation 5 Oth	ation 3 er Specify:		om State	-	elpi ce r on Co	n. m			Date 21/11		alt.,		own, State
Balt permit. Departs Import injury		21. Signature of Funeral Se	e			5	Name and A 126 B	ela.	ir R	d,B	alt.,	, MD		6 - 5	s,PA 105
Physician /Medical -xaminer		23a. Part I. Enter the diseas failure. List only one commediate Cause (Final dis or condition resulting in dea	ause on each ease a. G	iline. unshot W	ound of H	ead	the mode of	dying, si	uch as care	diac or r	espiratory a	rrest, sl	hock, or hea	rt	Approximate Interval Between Onset and Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ca	b	`	consequence	,							•	+	
uted of ansit	Examiner	(Disease or injury that initial events resulting in death) L		ue to (or as a	consequence	e of):									
50, ce be executed ysician and burial - transit	ledical	UNPENDED IF FEMALE:		AMENDED	outcome of pr	ognanov						12	3d. Date of	delivery	
Box 68760 ie death certificate bette attending physied for use as the bu	ysician/Me	23b. Was decedent pregnant past 12 months? 1 Yes 2 No 9 ✓		1 Live b	irth ant at time of	2 F	Fetal death Other (Specia	3 [_ fy)	Ectopic p	regnand	Э у		Month	Day	y Year
yrds, P.O. E w requires that the c s been signed by the should be detached	d by Phy	Part II. Other significant co	nditions co	ontributing to	death but no	t resulting in the	underlying o	ause giv	en in Part	I.				_	e cause of death?
2 a a 2	Completed							•			per 1 ✓ Yes	opsy form <u>ed</u> 1	pr de		psy findings available npletion of cause of
Vital Rechapsician: The this certificate of director, page	To Be	25. Was case referred to me examiner? 1 ✓ Yes 2 No		spital: 1 1	npatient 2	ER/Outpatie	nt 3 DC)A 0		Nursing	Home 5		dence 6		Scene
ion of tending Pheath. or: After the funeral			Pending Investigation	POUND FOUND Nov 11,	Day, Year)	28b. Time o FOUND: 1742 hrs	f Injury 28		at Work? s 2 ✓ N	S	^{8d.} Describe ubject sh	e how ir ot	njury occurre	ed	
Division To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification:	3 Suicide 6 4 Homicide	Could not be determined	28e. Place (Specify)	e of Injury - At Single Fa	home, farm, str amily Home				26	or Town, 312 Kentud	State) cky Av	enue, Balti	more, M	
To the Host within 24 h To the Fun completely	Medical	one) 2 Medical	Examiner: 0		of examination	edge, death occ n and/or investig						e and p	olace, and du	e to the	cause(s)
	ž	29b. Signature and title of co	e 1	40	lla	-0		License O.C.M					J. Date signe		
2		30. Name and address of pe Carol Allan, MD		Medical	Examiner	900 W. Ba	altimore S	treet, E	Baltimore	e, MD	21223				
St Regist	ate	31. Date filed (Month, Day, Y		32. Re	gistrar's Sign	Jan Sau	الما								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day 15 11:15 PM Physician/ Pagonis Patricia Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Glen Burnie Anne Arundel Baltimore-Washington Medical Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** April 19 1 🗆 M 2 🔀 F Months Days Hours .1934 Washington D.C Director 577-44-3634 Usual Residence of Decedent shov 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State with the Maryland Director notified 1 Yes 2 No 28a-f Maryland Anne Arundel Annapolis 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Examiner must be 23a Funeral 601 Canal Lane 21409 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Black White etc. ö þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: White "natural", Completed 3 Widowed 4 Divorced f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) 12 51 MOB Dependent Dependent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Page 1 and 2 should be G. Moinihan С. Katherine William Messink 8 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health 601 Canal Lane Annapolis, Maryland 21409 Barbara M. Stevanus (Niece) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) ☐ Burial 2 🗷 Cremation 3 ☐ Removal from State ō Department of Important: If any injury or once. 11/16/2011 Bayview Crematory Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 23a. Pat. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph_sician/ VUSEDSIS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Fur hours after death.

Fur hours all precore. After this certificate has been signed by the attending physicis eted filled in by the funeral director, page 2 should be detached for use as the burner. Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 1 ☐ Yes ∠ I g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 Yes 1 Yes 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 🗆 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical

State

within 2 To the F

29a. Certifier

(Check

only one)

31. Date filed (Month)

29b. Signature and title of certifier

Name and address of person who completed cause of death (Item 23a) (Type Print

Registrar DHMH 17 Rev 7/2009 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

pense number 141365

Date signed (Month, Day, Year)

ovember

2011

2016

JOAN M. PYYOR

			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
			State of Maryland / Department of Health and Mental Hygiene
			1- State Registrar Certificate of Death Reg. No. 2013 36582
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Ton Monto Pryor 2. Date of Death Month Notemper Day 14 2 Year 9:54 Am
Ø	Examin		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 8 IN A PIT A PARTICLE AND A PARTI
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1
	land show d at	tor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
	he Maryla or 28a-f s e notified	Direct	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?
	h with the ns 23a const be	Funeral Director	7109 Portmouth Kd 21244 USA
980	filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	by	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1
5-0	2 hours aft "natural", edical Exa	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working
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	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last) Charles Lee Pryor, Sr. Bernade He Duvall
Maryland	1 and 2 should be filed within 72 hour if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical		192 Informant's Name/Relationship (Type, Print) Ralph A. West 9777 Bon Haven Lu, Owings Wills, MD
			20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place) 20c. Location - City or Town, State
Baltimore,	t. Pag tmen tant: jury		4 Donation 5 Other (Specify) Metro 11 18 20(1 Da FA IVICE, ME
Ba	permit. Departr Imports any inju		22. Signature of Tuneral Service Licenson 22. Name and Address of Facility Howeld Flexand Tolkie Aue, Balto His
	Physician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death Onset and Death
	Medical Examiner		Supple - Authorizant humanistansion
	ed nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury
	e executed ian and urial-transit		that initiated events c. Due to (or as a consequence of):
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, P.O.	The law requires that the ate has been signed by the page 2 should be detach		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown
ords	w requires been seen seen seen seen seen seen se	Completed by	Mannaic Victural Nivol
Rec		Com	autopsy performed? death? 1 Yes 2 No 1 Yes 2 No
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of Vital Records,	Attending Physician: or death. ector: After this certific by the funeral director.	ate: To	27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Death injury (Month, Day, Year) 27. Manuel 5 Panding
Division		Certificate:	Accident Investigation Accident Investigation Accident Investigation Accident Accident Accident Investigation Accident Accident Accident Accident Accident Accident Investigation Accident Accident
Ö	the Hospital or thin 24 hours afte the Funeral Dir mpletely filled in	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
	the Ho thin 24 the Fu mpletel	Med	(Check only one) (Check only
٥	o o wit		29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) NoLomber 14 2211
	5 m		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SUNNU PAVE, MD SINU HD/PITAL + BALTIMORE
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signifure
			MALT A RALL LANCE

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			For State Registrar		State of M	arylan			nt of F te of E		ind M	_	giene Reg. N			
	Dharisis	/		e (First, Middle, Last	7)							2. Date of Dea	ath	2	0	з. та 6 Б в 3
- And L	Physicia Medio	al	John		Parkinson							Nov	12)11	3:00 a ^M
	Examin	er		not institution, give s ston Road	street and number)				,Town,or √Win	Location of dsor	Death			c. County Carro	of Death	
	Funeral		5. Social Security No	umber 6. Se			ast birthday)		er 1 Year	If Under 2	4 Hrs.	8. Date of Birt	h			lace (State or Foreign
	Director		069-46-4 Usual Residence of	744	57	7	Yrs.	IVIOITE I	54,5	, iodio	1	Mar 16	195	4	Count	NY NY
	land show dat	tor	10a. State	10b. County		10c. City	y, Town or Loc	cation							1	Od. Inside City Limits
	Mary 28a-1 notifie)irec	MD 10e. Street and Nun	Carrol1		New	Windso	_								1 ☐ Yes 2xxxNo
	with the	Funeral Director		nber ston Road					p Code L 776				-	itizen of ' J S	What Coun	try?
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Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau			osition Cremation 3 Other (Specify		20b. P	lace of Dispo- emetery, cren C. Cren	sition (Na natory or nato1	me of other plac y	e) No	_	5 2011			- City or To	
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_	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completed filled in by the	Medical	(Check 2	Certifying Physi Medical Examin Certifying Nurse	er: On the basis of e	xamination	and/or invest	igation, ir	my opinio	on, death occ	curred at	the time, date a	nd plac	e, and du	e to the cau	ise(s) and manner stated.
	To t with To tl		29b. Signature and t	n WM	ellita	mp			c. License		3				d (Minth, E	
	01		30. Name and address	ess of person who co		eath (Item	23a) (Type, P	rint)	KK	21. W	نعدا	trimol	ie.	m	02	1157
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DHMH 17 Rev 7/2009

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amend #30 Per DVR G921 11/16/2011 III
State of Maryland / Department of Health and Mental Hygiene

		•	For State Registrar	oraro or mary.	Ce	rtificate of L	Death	F	Reg. No.	11 26501
	Dhamisis	/	1. Decedent's Name (First, Middle, La	ast)			. =	2. Date of Dea	th ZU	3. Time of Death
	Physicia Medic		Dorothy J. Po					Novembe	er Dall Ži	011 5:00 P M
	Examin	er	4a. Facility Name (if not institution, giv	e street and number)			r Location of Death		4c. County of	
المحيد الم			Masonic Home 5. Social Security Number 6.	Sex 7. Age (In vr	s. last birthday)	If Under 1 Year	nt Valley I if Under 24 Hrs.	8. Date of Birth		Baltimore B. Birthplace (State or Foreign
2	Funeral Director				96 Yrs.	Months Days	Hours Min.	(Month, Day,	; Year)	Country)
	_ A		Usual Residence of Decedent					May 4,	1915 M	Maryland
	yland •f shc ed at	ctor	10a. State 10b. County	10c.	City, Town or L	ocation				10d. Inside City Limits
	e Mar r 28a notifi	Director	Md. Ba	ltimore		105 75- 0-1-	Phoeni			1 Yes 2 X No
	with th	Funeral I	2 Greenland Gar	th		10f. Zip Code	21131		10g. Citizen of Wha	JSA
	death items ier m		11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.	Was Decedent of H	lispanic Origin? (Spe an, Mexican, Puerto	ecify Yes or No-		American Indian,
Baltimore, Maryland 21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f show t, the Medical Examiner must be notified at	ed by	1 Never Married 2 Married 3 X Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates.	- 1	1 ☐ Yes 2 🔀 No		r wearr, etc.,	Specify:	White, etc. White
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lan	e d ta	မှု	Geo	_		:	Mar		Earnshaw	
ary	should be file n and Mental h 7 is marked o raumatic eve		19a. Informant's Name/Relationship (19b. Mail	ing Address (Street a	and Number or Rura	<u> </u>	City or Town, State	e, Zip Code)
Σ,	1 and 2 should be of Health and Menitem 27 is marke other traumatic.		Dennis E. Mitchel	1/Personal Re	p. P.O.	Box 0221	Hampste	ad, Mar	yland 210)74
ore			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 [Removal from State	cemetery, cre	osition (Name of matory or other plac	ce)	Date	20c. Location - Cir	•
tim	Page tment o tant: If jury or		4 Donation 5 XOther (Spec	ify) Entomb Du	laney V	alley Mem	n. Grid. 11	/16/11	Timonium,	, Maryland
Bal	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer	1 Null		1050 Yor	k Road T	owson,	Maryland	Home, Inc. 21204
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8760	ificate be executed g physician and as the burial-transit	Medical	IS SELVING	- u.	_					
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_	To the within 2 To the comple		29b. Signature and title of certifier	12	han	29c. License	e number	2	29d. Date signed (M	Month, Day, Year)
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6	· V		30. Name and address of person who John W. Bowie				e4902 Bali	timore,M	D 21204	
	Stat Registra		31. Date filed (Month, Day, Year) _ NOV 1 6 9	32. Registrar's Sig	nature	akel				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Jane Theresa Piette Nov 12, 2011 Year 6:35 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Columbia Howard Harmony Hall 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) Apr 3, 1924 1 □ M 2 🗙 F Days Hours Min. Months 016-20-8771 87 MA **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director MD Howard Columbia 1 🗌 Yes 2 🗶 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6336 Cedar Lane Funeral 21044 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Was Deceue... Armed Forces? Ves 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 nand Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Optical Co. Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Wladlyslaw Kozacki Julia Strek permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatto e 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rodney Piette 10277 Breconshire Rd. Ellicott City, MD 21042 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oakridge Cemetery Nov 23, 2011 Southbridge, MA 22. Name and Address of Facility SIACK Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 of Funeral Septe Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed -trar Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☑ No for Month Day Year Pregnant at time of death the ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 performed 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Spec 1 🗌 Yes 2 Y No မ 1 Inpatient 2 I ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural $5 \square$ Pending work? 1 ☐ Yes 2 ☐ No spital o.
4 hours after de.
• • ral Director: A* Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basks of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner.

State Registrar

completed

29b. Signature and title of certifier

30. Name and address of person whe

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Year!

DHMH 17 Rev 7/2009

ompleted cause of death (Item 23a) (Type, Print)

32. Registrar's Signatu

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month **Hope Madison Pham** 1058 AM 2011 Medical 4a, Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner **Baltimore City** more 8. Date of Birth (Month, Day, Year) Nov 8, 2011 Birthplace (State or Foreign Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 1 M 2 DV Days Hours Min. Months MD n/a Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director **Ellicott City** 1 Yes 2 No MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21043 5109 Sante Fe Ct. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian. 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Divorced 4 Divorced Year or Dates Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) infant infant Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Paul Lam Pham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5109 Sante Fe Ct. Ellicott City, MD 21043 Paul Pham father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2/Scremation 3 Removal from State Nov 14, 2011 Glen Burnie, MD **Atlantic Crematory, LLC** 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 Signature of Funeral Service Approximate Interval Between Onset and Death 23a. Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure, List only one cause on each line. Immediate Cause (Final Physician/ Premati xtreme disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Be Completed by Physician/Medical Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Burneral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy eral Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for i in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) Pregnant at time of death g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 2 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital Other: 2 No 1 Tes Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Quaske: Month Physician/ re 820 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Kesville arrol If Under 24 Hrs 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Country) S.C. 1 🗆 M 2 🕱 F Months Hours (Month, Day, Year) 06/11/1917 94 Director 249 03 8887 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Maryland 1 X Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 1 and 2 should be filed within 72 hours after death with the f Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a Funeral 4142 Doris Avenue 21225 U.S. 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: If Yes, Give Specify: White 3 x Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) Secretary Clerk Bethlehem Steel 8th injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Simeon Sanford Steele Flor Blanche Flowe 19a. Informant's Name/Relationship (Type, Print) Emory S. Quaskey / Son 535 Pembrooke Court Millersville, Maryland 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of H Important: If ite any injury or oth Page 1 1 Burial 2 Cremation 3 Removal from State Glen Haven Mem. Park 11/11/2011 Glen Burnie, Maryland 4 Donation 5 X Other (Specify) Entombment 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence) of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 the as 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Other (specify) Pregnant at time of death signed by the a a Unknown g 🗌 Unknown Hospital or Attending Physician: The law requires that the c24 hours after death.
Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2×No Division of Vital Records, 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital 2 XNo 1 Yes ပ 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: iniury work?
1 Yes 2 No 1 Natural 5 Pending Accident Investigation ☐ Acciden ☐ Suicide completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Registrar

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within 2 the

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29b. Signature and title of certifie

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filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Contribute the cause of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

21784

29c. License numbe

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Veronica Evelyn Reaves-Harvey Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Good Samaritan Hospital Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours Min 231-74-3745 Director 1 M 2 M F 60 July 15, 1951 Virginia Maryland 21215-0036 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Md N/A 1 Yes 2 No Baltimore 10e. Street and Number items 23a or 10f. Zip Code 10g. Citizen of What Country? by Funeral 5504 Govane Avenue USA 21212 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cyban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 Never Married 2 Married 0 Yes 1 ☐ Yes 2 Mo Specify: If Yes, Give "natural", Specify: Black 3 - Widowed 4 - Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene, is marked other tha Self-Employed Accountant 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Spencer Reaves Evelyn R. Belle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains William Harvey, Jr. - Husband 5504 Govane Avenue Baltimore, Maryland 21212 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)

Dulaney Val. Mem. Cardens 11/10/2011 1 M Burial 2 Cremation 3 Removal from State Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Servic Livensee 22. Name and Address of Facility Chatman-Harris Funeral Home any ir 5240 Reisterstown Road Baltimore, MD. 21215 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ph sician/ sease or condition Arry Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for rise as the burial through that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 No Yes 1 Yes 25. Was case erred to medical Be 26. Place of Death (Check only one) Hospital: Other: 2 No Certificate: To Yes 1 Inpatient 2 EB outpatient 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier November 5, 2011 40059540 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 00 Dre Registrar

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	State of Maryland / Department of Health and N	/lental Hygiene					
	Certificate of Death	Reg. No.	2	Ω		L	
iret	Middle Last)	2. Date of Death		•	•	٠,	

			Please	Type or Print in State of Marylar	Black Ir	ndelible Ink	. Ensure A	II Copies	Are Legible.	
		1	For State Registrar			tificate of D		Re	g. No. 201	1, 36589
	Physicia	n/	1. Decedent's Name (First, Middle, Last Nancy Jane Ryals)				2. Date of Death Month Novembe	Day 12, 2011	3. Time of Death 4:45 P. M
	Medic Examin		4a. Facility Name (if not institution, give s	treet and number)		4b. City, Town, or	Location of Death		4c. County of Deat	
; ^d	Funeral		3224 Orlando Ave. 5. Social Security Number 6. Sec		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	g. Birt	thplace (State or Foreign
	Director		213-60-3189	M 2 X F 59	Yrs.	Months Days	Hours Min.	(Month, Day,) Aug. 29,	1952 Ball	timore, MD.
	land f show d at	to	10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits 1 Yes 2 □ No
	or 28a-	Director	Maryland N/I 10e. Street and Number	A DO		10f. Zip Code		10	Og. Citizen of What Co	
	n with the same is 23a o	Funeral	3223 Orlando Ave.				21234			
9800	e filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 █ vivorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates.		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 X No	n, Mexican, Puerto Specify:	Hican, etc.)		white
15-0	72 hou n "natu Aedica	nplet	15. Decedent's Ed (Specify only highest gra	de completed)	(Give	dent's Usual Occupa kind of work done o O NOT use retired)	ation Juring most of work	ing	16b. Kind of Business	
212	ed within Hygiene. other thar		Elementary/Seconday (0-12)	College (1-4 or 5+) 02	a	stomer S			Becton Di	.ckenson
land	be filed ental Hy rked oth ic event	To Be	17. Father's Name (First, Middle, Last) Raymond Gonzales					ne (First, Middle, M M. Ulato		
Maryland 21215-0036	of and 2 should be file of Health and Mental H fitem 27 is marked of r other traumatic ever		19a. Informant's Name/Relationship (Ty Mrs. Rosalie G. G		19b. Maili 20 H	ng Address (Street a	and Number or Rur d Drive	al Route Number, Balti	City or Town, State, Zi	Land 21234
Baltimore,	Page 1 and ment of Hes ant: If item ury or othe	- 3	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Specific	1	comptony cre	osition (Name of matory or other place Memorial	Park Nov	5d	20c. Location - City or Baltimo	Town, State re, Maryland
Baltir	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	Jeffrey L.Gair,	Sr.CFSP2 0677	2 Name and Address Persoeful Al 2325 York	ss of Facility Templives Road Tir	Funeral ar	d Cremetion dand 2109	Center, P.A. 3-2215
	Physician/) Medical Examiner		23a. In the residisease, morning shock, the intralidure. List only of immediate Cause (Final disease or condition resulting in death) Sequentially list condition if any, leading to immediate cause. Enter Underlying	a. Due to (or as a consect b. Due to (or as a consect b.)	th. Do not ent	er the mode of dyin	g, such as cardiac	or respiratory arre	st,	Approximate Interval Between Inset and Death
_	be executed sician and burial-transit	cal Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consected)	quence of):					
68760	ath certificate be attending physici for use as the bu	/Medi	IF FEMALE:	23c. If yes, outcome of pregr	nancv				23d. Date of de	elivery
Box	ne death ce y the attenc ched for us	Physician/Medica	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live Birth 2 Fe 4 Pregnant at time of 9 Unknown	tal death 3	☐ Ectopic pregnand ☐ Other (specify)	cy		Month	Day Year
s, P.O.	requires that the de been signed by the should be detached	b	Part II. Other significant conditions of	ontributing to death but not re	esulting in the	underlying cause gi	ven in Part I.	23e. Did tol	N/ -	to the cause of death? Probably 4 \square Unknown
Division of Vital Records,		Completed						24a. Was a autop: perfor	med? death?	utopsy findings available completion of cause of les 2 \(\square\$ No
ital	Physician: The laver this certificate haver all director, page 2	Be	25. Was case referred to medical examiner?	Hospital:	7 ====	Ott	lace of Death (Che	5.4	ence 6 Other (Spe	acifu)
of V	g Phys er this neral dii	te: To	27. Manger of Death	1 Inpatient 2 2 28a. Date of injury (Month, Day, Year)	28b. Time of injury		ry at		ow injury occurred	
vision	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral	Medical Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	n	home, farm, st	M 1 🗆	Yes 2 No	28f. Location (Si City or Town	reet and Number or R n, State)	tural Route Number,
۵	Hospital or Attendi 24 hours after death. Funeral Director: A eted filled in by the fu	dical	101 1 0 0 15 15 15	sician: To the best of my kno iner: On the basis of examinat	on and/or inve	etigation in my onin	ion death occurred	at the time, date at	id place, and due to the	e cause(s) and manner state
	To the I within 2 To the I comple	Ž	only one) 3 Certifying Nur 29b. Signature and title of certifier	se Practioner: To the best of	my knowledge	29c. Licens			29d. Date signed (Mor	
			> / Q	A CR.		RC	9393	5	11/14/11	
2	-		30. Name and address of person who	completed cause of death (Ite		ER N7	> ′			
	Sta		31. Date filed (Month, Day, Year)	32. egistrar's Sign	nature	reves				
/ DH	Regist			Janes Comment	1					

State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / D	epartment of Heal Ce <i>rtificate of Dea</i>	+h		
			Registrar 1. Decedent's Name (First, Middle, Last)	Jeruncale or Dea	2. Date of De	Reg. No. 20	1, 36596
	Physicia				Month November	Day Year	5:15 P M
, mar.	Medic Examin		Evelyn C. Rossi 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Loca		4c. County of Deat	
	Examil	lei	21637 Railroad Ave.	Freeland		Baltimon	
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birth)	day) If Under 1 Year If U	Inder 24 Hrs. 8. Date of Bird	h 9. Bir	thplace (State or Foreign untry) Odenton
	Director		219–30–5824 1 □ M 2 ^X F 96 Y	rs. Months Days Ho	ours Min. (Month, Da	21°, 1915 Mai	ryland
	d ow f		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits
	arylan a-f sh îed a	cto					1 Yes 2X No
	or 28	Dire	Maryland Baltimore Freela 10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?
	with ti	eral	21637 Railroad Ave.	21053		U.S.A.	
	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispani	ic Origin? (Specify Yes or No-	14. Race - Ame	rican Indian,
9	ter de , or it	by	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ⚠ No	If Yes, specify Cuban, Me 1 ☐ Yes 2 🔀 No Sp	exican, Puerto Rican, etc.)	Black, White	
9	urs ar	ted	3 X Widowed 4 ☐ Divorced If Yes, Give Year or Dates.			Specify:	White
21215-0036	72 ho	Completed	(Specify only highest grade completed)	Decedent's Usual Occupation Give kind of work done during		16b. Kind of Business	Industry
12	ithin ene. r thar	မ္မ	Elementary/Seconday (0-12) College (1-4 or 5+)	fe. DO NOT use retired) memaker / S	Sales Clerk	Own Home	
	led w Hygi other	Be	17. Father's Name (First, Middle, Last)		Mother's Name (First, Middle,		
lan	be fi lental rked ric ev	잍	John Hess	Re	ebecka Campbel	1	
Maryland	ge 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print) 19b.	Mailing Address (Street and N	lumber or Rural Route Numbe	r, City or Town, State, Zij	o Code)
	and 2 s Health s tem 27 i		Mrs. Judy Dausinger (Daughter) 2	1637 Railroad	Ave. Freeland	d, Maryland	21053
ore	of He of He Fiten		20a. Method of Disposition 20b. Place of	Disposition (Name of crematory or other place)	November 16	20c. Location - City or	Town, State
Ë	Page ner		4 □ Donation 5 □ Other (Specify) Gar	crematory or other place) r Memorial dens	= 2011	Bel Air, N	Maryland _
Baltimore,	permit. Page 1 and 2: Department of Health Important: If item 27 any injury or other tr		21. Signature of Funeral Service Licensee Teffrey R. Teste	Evans Funer By S Funer 3 Newport Driv	Facility ral Chapel & Crem e, Forest Hill, N	ation Services aryland 2105	Bel Air
			23a. Part I Enter the disease, or complications that caused the death. Do no shock, or beart failure. List only one cause on each line.	t enter the mode of dying, suc	ch as cardiac or respiratory ar	rest,	Approximate Interval Between
	hysician/		Immediate Cause (Final disease or condition	oThrive			Onset and Death
	Medical Examiner		resulting in death) a. Due to (or as a consequence of				
	Examine	<u>.</u>	Sequentially list conditions, b. Hypertens	SION			
	sit sit	Examiner	if any, leading to immediate Due for as a consequence of cause. Enter Underlying Cause (Disease or initiury):			
	and and Il-tran	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of	<u> </u>			
0	ate be executed bhysician and the burial-transit	dical					
200	icate phys s the	ledi	d				
189	eath certifice attending p I for use as 1	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death	D Catania numerono.		23d. Date of de	livery
Box	d for	sicia	1 Yes 2 No 4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
Ö.	t the dea by the a tached	Phys	9 🗆 Ofiknown				
P.O.	es that signed be be det		Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in	I _	obacco use contribute to	
rds	require been si should	Completed by			1 □		Probably 4 Unknown
8	law re nas be	ld l			24a. Was		rtopsy findings available completion of cause of
Re	The sate h	S			1 Yes	ormed? death? 2 No 1 ☐ Ye	s 2 No
ta	ician: The la certificate harector, page	Be	25. Was case referred to medical examiner?	26. Place o	of Death (Check only one)		
of Vital Records,	Physical this cal dir	<u>ان</u>	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Out 27. Manner of Death 28a. Date of injury 28b. Ti	batient 3 L DOA 4	Nursing Home 5 Residue A	dence 6 Other (Spectors)	cify)
n o	ding I th. After funer	sate		ury work? M 1 \sum Yes		low injury occurred	
Sio	Atten r dear ctor; by the	Certificate:	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm		28f, Location (S	Street and Number or Ru	ıral Route Number,
Division	al or safte		building, etc. (Specify)		City or Tov	/n, State)	
	ospit hour unera	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, d (Check 2 Medical Examiner: On the basis of examination and/or				
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Me	only one) 3 Certifying Nurse Practioner: To the best of my knowle	dge, death occurred at the time	e, date and place, and due to th	e cause(s) and manner as	stated.
	Vittle Cor		29b. Signature and title of certifier	29c. License num		29d. Date signed (Mont	
			· IIII OWA IND	MDOO	28626	rovembe	(11, 2011
?			3). Name and address of person who completed cause of death (Item 23a) (T	Pe, Print) #200	58656 5 TOWSON 1	10,2120	14
	Sta	te.	31. Date filed (Month, Day, Year) 32 Registrar's Signature	2.41	J IVWSUN (113/3/20	4
	Pagietr		NUV 1 6 2017 Chause B.	paire			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36591 Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death MOU Physician/ So Binson Medical AMES 4c. County of Baltimore 4a. Facility Name (if not institution, give street and number) **Examiner** ty. Town, or Location of Dea Randa I I stown Season's Hospice Social Security Number 8. Date of Birth (Month, Day, Year) 11/17/1950 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Months Days Hours unkn. Director 60 1 X M 2 T F unkn. show 10a. State 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits with the Maryland Director MD Baltimore 28a-f 1 X Yes 2 No 10e. Street and Number 511 Park Avenue ō 10f. Zip Code 10g. Citizen of What Country? Funeral 21201 **23**a USA items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Medical Examiner Black, White, etc ō þ 1XXNever Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 filed within 72 hours after 2 X No White 1 Yes 2 X No Specify. "natural" 3 Divorced 4 Divorced Specify Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the unkn. unkn. other traumatic event, Be Department of Health and Mental H
Important: If item 27 is marked or any injury or other *** 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ unkn. unkn. 19a. Informant's Name/Relationship (Type, Print) b. Mailing Address (Street and Number or Rural Route Number, 509 Park Avenue, Baltimore, Siglinde Holmes / Friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Chesapeake Crematory 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/10/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Marshall 21. Signature of Funeral Service Licensee orota 22. Name and Address of Facilit 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami y physician and Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Box 68760 as attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ 23d Date of delivery Por in the past 12 months? Dav Pregnant at time of death Yes 2 No the g Unknown g Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate 1 Yes Yes Hospital or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital: 1 Yes Other: 잍 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After tompletely filled in by the funer Matural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check

State Registrar

29b. Signature

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name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 36592 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Albert Eugene Rexroad November Day 3, 2011 2:55 AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore Examiner 4b. City, Town, or Location of Death Stella Maris Hospice Timonium If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 212-38-5083 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 71 (Month, Day, Year) 04/24/1940 Director 1 🗶 M 2 🗆 F MD 10b. County the Maryland 10a State 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Harford White Hall 28a-f 1 Yes 2 X No 10e. Street and Nu. 5167 10f. Zip Code items 23a or ner must be n 10g, Citizen of What Country? Norrisville Road 21161 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Coast If Yes, Give Year or Dates.Guard Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, the Medical Examiner Black, White, etc. ō þ 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: spewhite "natural", Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Retail Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rexroad Albert Lydia Lepley uege 1 and 2 sh uepartment of Health and Important: If item 27 is m any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joy Elaine Rexroad / Spouse 5167 Norrisville Road, White Hall, MD 21161 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 $\cancel{\ \ }$ Cremation 3 \square Removal from State Chesapaeake Crematory 11/15/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Foreral Service Licensee Dorota Marsha Maryland Cremation Services PO BOX 1413, Baltimore, MD 21203 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) LUNG CANCER Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 4 ☐ Pregnant : 9 ☐ Unknown 1 ☐ Yes 2 ☐ 9 ☐ Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 🗙 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 X Other (Specify) HOSPICE 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 1 X Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 X Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 14 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TRACIE MORGAN, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (N Registrar's Signa State

DHMH 17 Rev 06-2011

Registrar

a.m.

2011

NOVEMBER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36593 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month James Kermitt Ross, Sr. 05 2011 Nov. 1604P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Hours 04/21/1949 577-64-5329 Washington, DC **Director XX**M 2 □ F 62 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director MD PG Capital Heights 1X Yes 2 □ No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? 23a Funeral 20743 4821 Heath Street USA items 2 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Examiner Black, White, etc 1 Never Married 2 Married 1 X Yes 2 □ No
If Yes, Give
Year or Date6 9 - 70 "natural", or þ Maryland 21215-0036 within 72 hours after 1 ☐ Yes XXNo Specify: Specify: Black 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Printer years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sarah Lawson John Ross Page 1 and 2 should ment of Health and Me 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2074327 4821 Heath Street, Capital Heights, James K. Ross, Jr (Son) Department of Health Important: If item 2: any injury or other tonce. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/16/11 MD Veteran Cem Cheltenham, MD 4 Donation 5 Other (Specify) Sign 22. Name and Address of Facility Freeman Funeral Services MD 20748 4594 Beech Road; Temple Hills, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List on young cause on each line. Cause (Final Onset and Death **Immediate** Ph_sician/ 140CARDIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last physician Physician/Medical The law requires that the death certificate be attending IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year be detached the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has filled i by the funeral director, page 2 autopsy performed within 24 hours af er death.

To the Funeral Director: After this certificate 2 🗌 No Yes 2 No 1 Tyes Hospital or Attending Physician: 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Certificate: To Be examiner? Hospita Other: 4 \nearrow Nursing Home 5 \square Residence 6 \square Other (Specify) 2 🕦 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1 Natural 5 Pending work 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month. Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Mo.

ROSC

Forest Glen Medical Center

9801 GA,

Silver

Ave.

#227

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

egistrar's Signati

Vemury,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NOVEMBER TY PATRICIA MARY RICHMOND 8:59 D W Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERTCK FREDERICK 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8 Date of Birth 9 Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 F 1473/1924 Mary Tand Director 87 220_14_9111 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d Inside City Limits Director 1 ☐ Yes 2 X No Maryland Frederick Walkersville 10e, Street and Number ō 10f. Zip Code 10g, Citizen of What Country? the Medical Examiner must be Funeral 23a U. S. A. 21793 15 Maple Avenue items ? 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. ō à 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 'natural", Specify: 3 XWidowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) 4 Computer Analyst Government Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lula Skillman traumatic John Patrick Sweeney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Walkersville, Maryland 21793 Susan Marie Kierson (Daughter) 15 Maple Avenue Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 \square Cremation 3 \square Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Belair Memorial Gardens Bel Air, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Bruzdzinski Funeral Home 1407 Old Eastern Avenue PA Essex, Maryland 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between nset and Death Immediate Cause (Final Ph sician/ Neumy disease or condition lus Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical that the death certificate be Box 68760 attending IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown be detached the 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? certificate 2 No Yes 2 N Division of Vital 25. Was case referred to medical funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA hours after death. neral Director: After this 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 ☐ Yes 2 ☐ No the f 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Gertifying Nurse Practioner: To the best of my knowled 29b. Signature and title of certifier 29c. License number

Registrar

DHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last, 2. Date of Death Physician/ 0838 Northber awrence mman Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Medical Cen Tou Social Security Number Year If Under 24 Hrs. 8. Date of Birth (Month Day, Apr 28, If Under 1 9. Birthplace 7. Age (In vrs. last birthday) (State or Foreign **Funeral** 1 Ø M 2 □ F Days Hours Min 435-33-4938 Months 46 OUISTAN A Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director FREDERICK MD. FREDERICK 1 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 2157 BRISTOL DR. 21702 USA filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) h and Mental Hygiene.
7 is marked other than "r traumatic event, the Med MONTGOMERY Elementary/Seconday (0-12) College (1-4 or 5+) TRASH TRUCK HELPOR SCHOOL SYSTEM Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be ment of Health and Menta SIMMONS SR MARY ALLCE WALTER SCOT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. 2157 BRISTOL DR. FREDERICK MARVIAND PAULA MOORE FRUOVA Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State NOV. 19,2011 FRODERICK MD. ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licerse 22. Name and Address of Facility GARY L. ROLLINS FUN. Itum & SOUTH ST FRED BRICK MD 110 WUST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 000 Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence on): Cause (Disease or linjury that initiated events the burial-trans Due to (or as a consequence of) resulting in death) Last sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has autopsy perform death? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ျင 1 Inpatient 2 I ER/Outpatient 3 TOOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the ca only one 29b. Signature and title of derivier Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar d crezo

31. Date filed (Month, Day, Year)

WV

32. Registrar's Signature

M

21742

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36596 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 03.40 AM Physician/ Alice Street-Sparrow 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** HUSPITAL BALTIMORE N/AAGNES 57. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Social Security Number 213-60-5860 **Funeral** Months 10, Director Maryland 1952 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland items 23a or 28a-f sho ner must be notified at Director 1 Yes 2 No Baltimore Maryland N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21229 Funeral 5222 Hillwell Road USA Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No ò þ 1 Never Married 2 Married Specify Black altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes. Give "natural", Completed 3 Divorced Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Care Provider 12th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ge 1 and 2 should be fil nt of Health and Mental :: If item 27 is marked ၉ Betty Hill Frank Coleman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 19a. Informant's Name/Relationship (Type, Print) 2706 E. Preston Street Baltimore, Maryland 21213 Kellie Coleman/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Department of Important: If any injury or 11/17/11 Pikesville, Maryland Druid Ridge Cemetery 21. Signature of Janeral Service Licents 22. Name and Address of Facilit Chatman—Harris Funeral Home \$240 Reisterstown Road Baltimore, Maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death er the dis e. List only one cause on each line Immediate Cause (Fin. FOUR DAYS Physician/ PN EUM. NIA disease or condition Medical resulting in death) Due to (or as a consequence of): FEW M. NTHS Examiner CANCER UNG Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated surface). Examine Due to (or as a consequence of) the burial-transit that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Physician/Medical Sykefa 7 ALCE Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ I or Attending Physician: The law requires that the death safter death.

Director: After this certificate has been signed by the atter in the past 12 months?
1 ☐ Yes 2 🗷 No Month Day Pregnant at time of death 4 ☐ Pregnant 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ EMB.LISM 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 💢 No 1 Npatient 2 ER/Outpatient 3 DOA Certificate: To 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛛 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined To the Hospital within 24 hours a To the Funeral C Hospital Medical 1 K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 00 6 62634 MO, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) COLUMBIA MATERN AWAN 10796 HICKORY RIDGE RD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 20 36597 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ NO VE MOFIL 8:00 AM 201 Medical 4a, Facility Name (if not institution, give street and number 4b City Town, or Location of Death 4c. County of Death Examiner 96 RACE ANOVE Security Number If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours Min **Director** 28a-f show 10a. State 10b. County 10d. Inside City Limits items 23a or 28a-f sho her must be notified at 10c. City, Town or Location Director ANOVER 1 Yes 2 No 10g. Citizen of What Country 10e, Street and Numbe Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, the Medical Examiner Armed Forces Black, White, etc. ō 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 Yes 2 No 4 Divorced "natural", Completed 3 Widowed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic 19a. Informant's Name/Relationship (Type, Print) L3Rotul 19b. Mailing Address (Street nd Number or Rural Route Number, City or Town, State, Zip Code) 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ arrhythmia ardial disease or condition 1110 Medical resulting in death) Examiner 10015 Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events pertension 40015 and trar Due to (or as a consequence of) resulting in death) Last physician a sthe burial-Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 attending plant of for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Pregnant at time of death Month Day the 9 Unknown 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No Yes 2 N 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury_at 28d. Describe how injury occurred 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier

State Registrar Cham

32. Registrer's Sign ture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

NID

Date fled (Month, Day, Year

NOV 1 6 201

DZ1225

Drive #122 6190 Burnie, NO

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month R/1ZABE IMMONS Medical 4a. Facility Name (if not institution, give street and number) Town, or Location of Death 4c. County of Death 4b. City, **Examiner** edale altimore Somare Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. **Funeral** 213-32-8460 Director 1 🗆 M 2 🔀 F MAMIAND show 10a. State 10c. City, Town or Location must be notified at Completed by Funeral Director 1 🗌 Yes 2 🔼 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Joodcros 23a items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?
1 ☐ Yes 2 🗷 No 1 Never Married 2 Married ò 1 Tes 2 No altimore, Maryland 21215-0036 and Mental Hygiene.

Is marked other than "natural", If Yes Give Specify 3 ₩idowed 4 □ Divorced White Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry life DO NOT use retired Elementary/Secondary (0-12) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ WeN RICC Kerrick traumatic 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bever of Health If item 27 234 Forrestdale other t 20a. Method of Disposition 20b. Place of Disposition (Name of ☐ Burial 2 Cremation 3 ☐ Removal from State cemetery, crematory ō Important: If any injury or once. 11-15-2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Tosuph 22. Name and Address of Facility 263 16 23a. Part 1. Enter the disease shock, or heart failure. Us pplications that caused the death. Do not enter the mode of dying, such as cardiae or respiratory arrest, one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical (or as a consequence of **Examiner** Sequentially list conditions Sequentially hist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and as the burial-trar Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Dav Year Pregnant at time of death 1 Yes 2 b Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autopsy yes 2 No 1 Yes 2 No completely filled in by the funeral director, the Hospital or Attending Physician: 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 2 🗹 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 🗹 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0 Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 iave !

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** DAVIDS, SOCHER 2011 Jorember 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 ★ M 2 □ F 212-90-4093 January 3,1969 Maryland Director Usual Residence of Decedent 10d. Inside City Limits the Maryland or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2X No Director Maryland Dunda1k Baltimore 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ö death with ral", or Items 23a o Examiner must be 1903 Tolson Avenue 21222 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 2 3 Widowed 4 Divorced White "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 al Hygiene. College (1-4 or 5+) the Merchandiser Pepsi uth and Mental Hygid 27 is marked other r traumatic event, ti 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert M. Socher Judith Hacker ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health iem 27 i 719 Maiden Choice Lane; BR306 Catonsville, Maryland 21228 Robert M. Socher (Father) other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of h
Important: If ite
any injury or ot
once. 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-16-2011 Waldorf, Maryland Hunt Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of FacilitySterling-Ashton-Schwab-Witzke Funeral MOIOSC Home; 1630 Edmondson Avenue Catonsville, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** SE(disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Ulsease or injury that initiated events Examiner Due to (or as a consequence of) nding physician and use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ☐ Live birth 2 ☐ Fetal death in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the at ald be detached f 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 Number Completed should peen 24b. Were autopsy findings available prior to completion of cause of death?

1

✓ Yes 2

No 24a. Was an page 2 autopsy has performed? 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 → npatient 2 □ ER/Outpatient 3 □ DOA Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 TYes 2 **X**000 ၉ the funeral 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural (Month, Day Year) 1 | Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760, after death. Director: After this or Attending filled in by Hospital 24 hours

within 24 hou

To the Funer

completely fi the

Medical 2 🗋 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number M.D. RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D 3 RUN 31. Date filed (Month, Day, Year)

State Registrar 29a. Certifier

4940 Eastern Avenue, Baltimore, MD, 21224

29d. Date signed (Month, Day, Year)

November 11, 2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month William Henry Newnam Shure 4:30 P M NOvember Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Edenwald Baltimore Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Dec. 20 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Days Hours Min Mary Land Director 213-14-4209 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland 10d. Inside City Limits Funeral Director 1 Yes 2X No MD. Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a o Examiner must be 800 Southerly Rd. 21286 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: White Specify: 3X Widowed 4 □ Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done duning most of working life. DO NOT use retired) e 1 and 2 should be filed within 72 l t of Health and Mental Hygiene. If item 27 is marked other than "r or other traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) Engineer Mechanical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Austin Fernee Shure Grace Newnam 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lucinda Shure/ Daughter 1822 Clearwood Rd. Baltimore, MD. 21234 Page 1 and 2 Baltimore, Important: If item any injury or othe 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Department of 1 🙀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation ∱ Dother (Specify) Church Hill Cemetery 11-15-11 Chestertown, MD. 22. Name and Act to Towson Funeral Home, 21. Signature of Funeral Service Licensi 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or comp ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 3 \square Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Pregnant at time of death 5 Other (specify) Day Year 1 ☐ Yes ∠ ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 2 100 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: မှ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death.

Funeral Director: After Natural 5 Pending Accident 1 Yes 2 No Investigation filled in by the Suicide 6 Could not be Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

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Novembe

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifie

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Schen

CRNP

CKNI

29c. License number

800 Southerly Rd

R154032

Tausan, MD 21286

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36601 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Anna Ruth Stevens Nov 10, 2011 Year 9:40 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Gilchrist Hospice of Howard County Columbia 5. Social Security Number If Under 24 Hrs. Age (In vrs. last birthday If Under 1 Year **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗷 F Months Days Hours Min. th, Day, Year) Sep 26, 1916 218-36-8036 MD Director Usual Residence of Decedent at 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director notified 28a-f MD **Baltimore** Catonsville 1 Yes 2 No 10e. Street and Number b 10f. Zip Code items 23a or ner must be r 10g. Citizen of What Country? Funeral 125 Rosewood Ave 21228 U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. ò ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: "natural", Completed 3 Widowed 4 Divorced Specify Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Il Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) **Administrative Assistant** Spring Grove Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F is marked o ဂ Charles Stevens Anna Ray Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9015 Marcella Ave Randallstown, MD 21133 item 27 Ellen M. Van Wagoner or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State Atlantic Crematory, LLC Nov 14, 2011 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service dio nsee 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 mo1293 Part 1. Safer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or linjury burial-transi that initiated events resulting in death) Last Ж Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☑ Yes 2 ☐ No 9 ☐ Unknown Day Year Pregnant at time of death the detached 9 Unknown signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed has been si e 2 should l 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b, Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page performed? Yes 2 No certificate 2 No 1 Yes After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 🗌 No ဂ္ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending work' thin 24 hours after death.

the Funeral Director; Af
mpleted filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24

To the F

complet Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature a

31. Date filed (Month, Day, Year)

nd title of certific

DANIEUE DOBERMAN, MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

D64395

6336 CEDAR LANE COLUMBIA, MB 21044

29d. Date signed (Month. Day, Year)

NOVEMBER 10, 2010

11-08256 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Jordan Lamar Taborn 1. For State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day November 4, 2011 0700 hrs **Medical Examiner** Jordan Lamar Taborn 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Prince George's 2095 Addison Road District Heights 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs **Funeral** Country) Davs Hours Director 1XXM 04/15/1999 Washington 12 214-55-1184 Usual Residence of Decedent 10d. Inside City Limits iny 10a. State 10b. County 10c. City, Town or Location 23a or 28a-f show notified at once. MD Charles Waldorf should be filed within 72 hours after death with the Maryland and Mental Hygiene. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12226 Sweetwood Place 20602 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' White, etc. 1 X Never Married 2 Married Yes Black 3 Widowed 4 Divorced If Yes Give Year 1 Yes 2 No specify: Specify 3 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 7th Student Middle School 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Gregory Taborn Tonya Johnson rmit. Pages I and 2 should be epartment of Health and Ment nportant: If item 27 is mark jury or other traumatic ever 19a. Informant's Name/Relationship (Type, Print) Tonya Johnson (Mother) 12226 Sweetwood Place; Waldorf, MD 20602 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place! 1 XBurial 2 Cremation 3 Removal from State permit. Page Department 11/17/11 Hertiage Cemetery **p**onation ₁5 Othe Specify ture of Furgeral Service Licensee 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD Therefore diseas a trecomplication of the control o Enter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** /Medical DIPHENHYDRAMINE INTOXICATION Immediale Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical UNPENDED physician the burial AMENDED law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Fetal death Month past 12 months? Pregnant at time of death Other (Specify) 5 Yes 2 No 9 Unknown Unknown should be detached contributing to death but not resulting in the underlying cause given in Part I. ≥ Completed 24a. Was an autopsy has performed? death? page Yes 2 No 1 🗸 Yes 25. Was case referred to medica 26. Place of Death (Check only one) director. Be examiner? Hospital: 1 Other₄ Nursing Home 5 Residence 6 Other: Scene DOA Inpatient ER/Outpatient 3 this ۵ 1 🗸 Yes 2 No 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred

1 X Yes 2 No 14. Race - American Indian, Black 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20c Location - City or Town, State Waldorf, Maryland 20748 Approximate Interval Between Onset and Death of Vital Records, P.O. Box 68760, Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 V No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 2 No Hospital or Attending Physician: After 28a. Date of Injury (Month, Day, Year) Certification: found at Division Yes 2X No Natural Pending within 24 hours after death.

To the Funeral Director: SUBJECT INGESTED DRUG filled in by the found 11-4-1 6:45 AM Accident Investigation 28f. Location (Street and Number or Rural Route Number or Town, State) 2095 ADDISON ROAD. 28e. Place of Injury - At home, farm, street, factory, office building, etc з XX_{Suicide} Could not be 4 Homicide determined RESIDENCE <u>DISTRICT HEIGHTS, MD</u> 29a. Certifier 1 completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical To the Medical Examinar: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number O.C.M.E. November 5, 2011 OCME 30. Name and a dress of person who amplehed a use of death (Item 23a) Mary G. apple MD. Deputy Chief Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year, egistrar's Signature State acker Registra **ORIGINAL** OCMF 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland 1- For State Registrar	/ Department of Certificate of	Health and Mental H Death	ygiene Reg. No	2011 3660
Physician/	Decedent's Name (First, Middle,Last)			Date of Death Month Day November 11,	3. Time of Death 0839 hrs
Medical Examiner	Bob Tompkins 4a. Facility Name (if not institution, give street and number) [4	b. City, Town, or Location of Death		2011 0039 IIIS
1	Upper Chesapeake Hospital	′	Bel Air		Harford
Funeral	5. Social Security Number 6. Sex 7. Ag	ge (In yrs, last birthday)	If Under 1 Year If Under 24Hrs	–	//DD/YYYY) 9, Birthplace (State or Foreign
Director	215-68-1940 1Xm 2_F	57 Yrs.	Months Days Hours Min	Aug. 8,	
Þ.	Usual Residence of Decedent	10c. City, Town or Location			10d. Inside City Limits
W AN	10a. State 10b. County		in		1 Yes 2 X No
Maryland 28a-f show any d at once. rector	Maryland Harford 10e. Street and Number	Belcamp	10f, Zip Code	I 10a. Cit	tizen of What Country?
the Marylanc a or 28a-f sh tified at onc	1200 Magness Court		21017		SA
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Faut: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 12. Was Decedent		Decedent of Hispanic Origin? (Sp	pecify Yes or No-	14. Race - American Indian, Black,
or items 23 unit be no Funeral		X No	s, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.
ral",	3 Widowed 4 Divorced If Yes, Give Year or Dates:		Yes 2 No specify:	Transfer Transfer	specify: White
"natu Exan	15. Decedent's Education (Specify only highest grade cor Elementary/Secondary (0-12) College (1-4 or	during mo	s Usual Occupation (Give kind of v st of working life. DO NOT use reti		Kind of Business/Industry
5-0036 ed within 72 hour 15 yigien other than "natu the Medical Exar Completed	5+	Mini	ster	I	Religion
5-06 will led will led will let M	17. Father's Name (First, Middle, Last)		18.Mother's Name	(First, Middle, Maiden	
21215-0036 Juld be filed within 7 Mental Hygiers marked other than to event, the Medica	Robert Joseph Tompkins			/ Isabelle	
b 21 should and Me 7 is ma	19a. Informant's Name/Relationship (Type, Print)		Address (Street and Number or F		
and 2 sho ealth and tem 27 is traumati	Larraine Tompkins / Wife	20b. Place of Disposit	Magness Court,	Belcamp, No Date 20c.	Maryland 21017 Location - City or Town, State
TOFE at of H	1 Burial 2 Cremation 3 Removal from St	ate crematory or other	er place)	/10/2011	Morragon Marriland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be soiffed at once. To Be Completed by Funeral Director	4 Donation 5 Other Specify: 21. Sign for of Funeral Service Licensee		ervice Corp. 11/		Towson, Maryland eral Home, P.A.
E P P P P P P P P P P P P P P P P P P P	Parkara Purdu		1.10		don, Maryland 21009
Physician	23a. Part I. Enter the disease, or complications that caused failure. List only one cause on each line.				
/Medical Examiner		Cardiovascular Dise	ase	_	Death
	or condition resulting in death) Due to (or as a conse	equence of):			
ner	if any, leading to immediate Due to (or as a const	equence of):			
0, be executed sician and purial - transit	(Disease or injury that initiated events resulting in death) Last C. Due to (or as a conse	equence of):			
so, te be executed ysician and burial - transit	d.				
O, be exe visician a burial -	UNPENDED XX AMENDED #1	as noted G9	21 11/16/2011 J	Н	
ficate ficate g phys the b	IF FEMALE: 23c. If yes, outcor 23b. Was decedent pregnant in the		I death 3 Ectopic pregna		d. Date of delivery Month Day Year
Box 6876 e death certificate the attending phy ed for use as the I	past 12 months?	tion a of death -	I death 3Ectopic pregna er (Specify)	ricy	Month Day Year
the death certificate death certificate or the attending phend for use as the Physician/N	1 Yes 2 No 9 Unknown g Unknown				
Division of Vital Records, P.O. at or Attending Physician: The law requires that the repeated that the respector. After this certificate has been signed by led in by the fineral director, page 2 should be detachertification: To Be Completed by Pl	Part II. Other significant conditions contributing to deat	h but not resulting in the un	derlying cause given in Part I.		use contribute to the cause of death? No 3 Probably 4 V Unknown
fis, Figures and sign and be ted				24a. Was an	24b. Were autopsy findings available
Records, The law requires ficate has been sig , page 2 should be				autopsy performed?	prior to completion of cause of death?
Vital Recysician: The list certificate director, page On Be Con				1 ✓ Yes 2 N	No 1 Yes 2 No
ician sician s certi irector	25. Was case referred to medical examiner? Hospital: 1 Innatia	ent 2 🗸 ER/Outpatient	26.Place of Death (Check of 3 DOA Other Nursin		ence 6 Other:
n of Vi Jing Physi After this funeral dir	27. Manner of Death 28a. Date of Inju	ury 28b. Time of Inj		28d. Describe how inju	
ion tendin eath. tor: A the fu	1 V Natural 5 Pending (Month, Day,Y) 2 Accident Investigation	ear)	1 Yes 2 No		
Division o spital or Attending nours after death neral Director: After filled in by the funer Certification:	3 Suicide 6 Could not be 28e. Place of In	ijury - At home, farm, street,	factory, office building, etc.	28f. Location (Street a	and Number or Rural Route Number, City
Divisopital or A popital or A post of the Control o	4 Homicide determined (Specify) 29a. Certifier 4 Certified Physician To the heat of me				
F 4 4 4 5 5 1 12 1	one) Certifying Physician: To the best of m Check only Nedical Examiner: On the basis of examiner.				
5 1 2 1 2 L	29b. Signature and title of certifier		29c. License number		Date signed (Month, Day, Year)
	Unet ?		O.C.M.E.	Nov	vember 12, 2011
	30. Name and address of person who completed cause of d	,			
			nore Street, Baltimore, MD	21223	
State Registrar	31. Date filed (Month, Day, Year) (32. Registra NOV 1 6 2011	r's Signature			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 10:48A M Month NOVEMBER ,2011 Physician/ TAPPAN-BARLOW T.ET.A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK MEMORIAL HOSPITAL 7. Age (In yrs. last birthday) 67 vre If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Social Security Number 213-38-1967 **Funeral** 1 🗆 M 2 🛛 F Hours Min 0572771944 Spain **Director** Usual Residence of Decedent 10a. State 28a-f shov 10d. Inside City Limits 10b. Frederick 10c, City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at Director Frederick 1 X Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21701 798 Motter Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces?
1 ☐ Yes 2 🗶 No þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: permit, Page 1 and 2 should be filed within 72 hours aft. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Specify: 3 Divorced 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Interior Decorator Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Peter Tappan ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zio Code) 798 Motter Avenue, Frederick, MD 21701 William Barlow / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 11/10/2011 Beltsville, MD ^{22. Name and Address of Facility} remation Services PO Box 1413, Baltimore, MD of Funeral Service Licensee Darota Marshall Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 20 disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of): physician s the burial Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Month Day Year 5 Other (specify) the detached signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No 1 Yes 2 No certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? ဂ္ 1 🗌 Yes ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 🗆 funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: iniury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 0// person who completed cause of death (Item 23a) (Type, Print) 30. Name and address 1 una

DHMH 17 Rev 7/2009

State

Registrar

Registrar's Signature

16

NOV

State of Maryland / Department of Hea	elth and Montal Hya	
1 - For State of Waryland / Department of He. Certificate of De	aath	eg. No. 2011 36605
1. Decedent's Name (First, Middle, Last) MARGARET BLACK ULLE	2. Date of Deat Month Neweurk	Day Year
/Medical Examiner 4a. Facility Name (If not institution, give street and number) Roland Park Place Healthcare Center Baltimo		4c. County of Death N/A
Funeral Director 5. Social Security Number 219–32–8625 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Months Days Months Days	If Under 24 Hrs. 8. Date of Birth (Month, Day, Sept 1,	9. Birthplace (State or Foreign
Usual Residence of Decedent 10a. State 10b. County Maryland N/A Baltimore City		10d. Inside City Limits 11 Y Yes 2 □ No
Maryland N/A Baltimore City 106. Street and Number 830 West 40th Street 212.		0g. Citizen of What Country? USA
O = 5	panic Origin? (Specify Yes or No- Mexican, Puerlo Rican, etc.) Specify:	14. Race - American Indian, Black, White, etc. Specify: White
1 Yes, Give 1 Yes 2 No Standard 1 Yes 1 Yes 1 Yes 1 Yes 1 Yes Year or Dates 1 Yes Ye	ring most of working	16b. Kind of Business/Industry Developmental Disabil- ities
To be the state of	8. Mother's Name (First, Middle, I Margaret	Maiden Surname) Rice
Tr. Father's Name (First, Middle, Last) Walter Evan Black, Sr. Walter Evan Black, Sr. 19a. Informant's Name/Relationship (Type. Print) Margaret M. IIIle (Daughter) 2113 Fountain F	d Number or Rural Route Number	
		onium, Maryland 21093 20c. Location - City or Town, State
20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place) 20c. Method of Disposition (Name of cemetery, crematory or other place) 3	1	Baltimore, Maryland
Martin D. Lawson 6500 York Re	EDEFELD FUNERAL oad, Baltimore,	HOME INC Maryland 21212
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Physician Medical Medical Additional and additional additional and additional additional and additional ad		Approximate Interval Between Onset and Death Y
Medical resulting in death) Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Union that initiated events resulting in death) Last Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):		
p. p		
Solution Solution		23d. Date of delivery Month Day Year
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given Whome afral fubrillation The page 2 and 2 and 2 and 3 and 4 and		bacco use contribute to the cause of death? es 2 No 3 Probably 4 Unknown
The la Re has a gge 2 om p	24a. Was a autops perfor	sy prior to completion of cause of
25. Was case referred to medical examiner? 1 Yes 2 Yes Yes	26. Place of Death (Check only on	
The spiral of th	at 28d. Describe h	ence 6 LiOther (Specify) ow injury occurred
27. Manny of Death 1	28f. Location (S. City or Town	treet and Number or Rural Route Number, n, State)
29a. Certifier (Check only one) 29a. Certifier (Check only one) 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, 2 Medical Examiner: On the basis of examination and/or investigation, in my opin and manner stated.		
29c. License n 29c. License n D 1365		29d. Date signed (Month, Day, Year) Vouluber 14, 20 ((
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		
State Registrar NOV 1 6 2011 State Registrar	wij wijeriner	-/ /

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Day Year MCKINLEY **Physician** 40 A M WHITE 1.1 8 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Paltimore NIA evindalo Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

July 31, 1935 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, If Under 1 **Funeral** Months Days 246-50-920 1 M 2 □ F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 Nes 2 No altimore by Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Blac 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Jechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dures P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Whi Kd Satti More, ann 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 4 □ Donation 5 □ Other 3 ☐Removal from State Zior Other (Specify) of Funeral Service Licens 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) TONSILS Physician METASTATIC CANCER OF THE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Due to for as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this continued. as the burial-tran Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 1No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 📈 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifier PHYSICIAN -08-

State Registrar BABATUNDE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEVINGALE

GERHAMIC

BAITIMORE

MD21215

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 36607 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Joseph F. Ward, Jr. November 12, 2011 5:40 A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford Baltimore White Hall 19400 Ensor Road If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min Director 220-34-5260 1 💢 M 2 🗆 F 73 Feb. 27, 1938 Baltimore, Maryland Usual Residence of Dece or 28a-f show notified at Baltimore 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 X No White Hall Maryland Harford-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or r must be r ò United States Funeral 21161 19400 Ensor Road items death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: White "natural", 3 Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Local Union 101 Carpenter 12 of Health and Mental Hygi item 27 is marked other other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Helen M. Keeney Joseph F. Ward, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19400 Ensor Road White Hall, Maryland 21161 Priscilla Ward (Spouse) 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other 20c. Location - City or Town, State November 17, Department of Important: If it any injury or o once. ☐ Burial 2 X Cremation 3 ☐ Removal from State Evans Funeral Chapel-Bel Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2011 Δir Signature of Funeral Service License Name and Address of Facility Evans Funeral Chapel & Cremetion Services Monkton 16924 York Road Monkton, Maryland 21111 23a. Part 1. Englithe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or head/failure. List only one cause on each line. Interval Between Inset and Death Immediate Cause (Final disease or condition resulting in death) Physician Medical **Examiner** Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Examiner Due to (or as a nunsequence of): as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Other (specify) nse 23d. Date of delivery 23b. Was decedent pregnant for in the past 12 months? Month Day 1 Yes 2 No signed by the a Unknown P.O. not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant condition Be Completed by 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, eral Director: After this certificate has been si filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 🗌 No 1 1 ☐ Yes 2 ☐ ≺ 1 🗌 Yes 26. Place of Death (Check only one) examiner? Hospital ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending Accident Investigation 6 \square Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Day, Year) 8822 of death (Item 23a) (Type, Print) 31. Date filed (Month State NOV 16 Registrar

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	5. Social Security	Number	6. Sex 1X M 2 🗆	7. Age (In v	rs. last birtho		nder 1 Year	If Under	• •	8. Date of Bi (Month, D	irth		g. Birth	hplace (State
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	20a. Method of D 1 🔲 Burial	2 Cremation	3 Removal fro	om State	Ob. Place of D cemetery,	Disposition (i crematory (Name of or other plac			Date	20c. l	Location -	- City or T	Town, State
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Certificate: To Be Completed by Physician/Medical Examin	disease or condi resulting in death Sequentially list if any, leading to cause. Enter Unc Cause (Usease that initiated everesulting in death that initiated everesulting in death 1 Yes 2 g Unknow Part II. Other significant of Death 1 Yes 2 27. Manner of Death 1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	conditions, immediate derlying or injury nts nt pregnant 2 months? No with the condition of	b. Due d. C. Due d. 23c. If yes, the properties of the propertie	to (or as a constant to (or as	sequence of) seque	atient 3	26. Plate tory, office at the time, in my opiniocourred at the 29c. License	even in Part ace of Decer: 4 N 7 Yes 2 , date and n, death o e time, dat	ath (Check Jursing Ho	23e. Did 1 24a. Waa autur per 1 1 25 26 27 28f. Location City or To d due to the country date	tobacco Yes 2 s an opsy formed? s 2 how inju (Street an wm, State and place ause 29d. D.	wse cont 2 No 24b. No	onth ribute to 3 Pr Were aut prior to c death? 1 Yes er (Speci red er or Run er as state to the c anner as; d (Month)	ivery Day the cause of robably 4 [copsy finding completion of 2 No. 18] all Route Numeral Route N

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36609 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 13, 2011 John Milton Weaver III 1:50 P.M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 168 Rowlandsville Road Conowingo Cecil 5. Social Security Numbe 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth **Funeral** 1<u>943</u> 1 🔀 M 2 🗆 F Days 218-42-0991 Director 68 Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits Director r 28a-f sh notified a 1 Yes 2X No Maryland Cecil Conowingo 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? pe ms 23a must be Funeral 168 Rowlandsville Road USA 21918 12. Was Decedent Ever in U.S. n "natural", or iten ledical Examiner r 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Wldowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 11 Mechanic Spice Manufacturer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental Fishers is marked of ဂ္ John Milton Weaver Jr. Dorothy (unk) Lingner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a 168 Rowlandsville Road, Conowingo, Maryland 21918 Karen A. Weaver / Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or ott Page 1 a ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 11/17/2011 Towson, Maryland Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. Stesley <u>50 W. Broadway, Bel Air, Maryland 21014</u> 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Betweer Immediate Cause (Final Onset and Death BLADDIR CANCER Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ♣ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed? Yes 2 1 certificate 1 Tes 2 No Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending Natural 5 Pending injury work? Division within 24 hours after death.

To the Funeral Director; Af
completed filled in by the fu Accident Suicide Investigation 2 No Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of PHTS5 CZAN D0058475 LOVERBILR, 14, 2011 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PHOLED NOVATRUEN

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Simature

I SID UPPENCHESAPONKE PRINT, PIELATER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle | ast) 2. Date of Death Physician/ November Year 7011 Julie Wessells 8:30P M Medical 4a. Facility Name (if not institution, give street and number)
Season's Hospice 4b. City, Town, or Location of Death Randallstown 4c. County of Death
Baltimore **Examiner** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** Social Security Number 521 – 37 – 5743 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Birthpic CA 04/12/1971 Director 40 1 🗆 M 2XX F show ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Severn 1 XYes 2 No 10f. Zip Code 21144 10g. Citizen of What Country? and Number 8013 Completed by Funeral Brookmead Court be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes Give 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) d Mental Hygiene, marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Senior Consultant Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First Middle, Maiden Surname) and Mental F permit. Page 1 and 2 should be: Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ewonce. Wessells Wilson ಲ 19a. Informant's Name/Relationship (Type, Print)
Ann F. Wessells / Mother 19b. Mailing Address (Street and Number of Rural Route Number City or Tawn, State, Zip Cold 0526 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Chesapeake Crematory
11/11/2011 1

Burial 2

Cremation 3

Removal from State Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Maryland Cremation Services PO Box 1413, Baltimore, MD 21. Signature of Funeral Service Licensee Dorota Marshall Marshoul Pert 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Breast cancer disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician s the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Pregnant at time of death 5 Other (specify) Day Year 1 Yes 2x the a Unknown signed by t Id be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital Other: 1 Yes 2 🛂 No မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred after death. Director: After 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSRWapahuM.D 11/10/11 DOUS7465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21209 N.S Rayporker, M.D. Baltimore 2835 Smith AV 5203

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1

6

. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36611 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 9:50 PM CATHY WILT NOVEMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore, MD HARBOR HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 Days Hours 0192671959 MD Director Usual Residence of Decedent 10a. State or 28a-f shov 10h County 10d Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location **Funeral Director** Baltimore 1 X Yes 2 No 10f. Zip Code 21227 10e. Street and Number 10g. Citizen of What Country? 3001 Vermont Avenue Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black White etc. 1 ☐ Yes 2X No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Caregiver Healtcare Be 17. Father's Name *(First, Middle, Last)* **Charles Flippin** 18. Mother's Name (First, Middle, Maiden Surname) မ Jack Viola 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William C. Bazemore/Son 3001 Vermont Avenue, Baltimore, MD 21227 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 11/13/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility}
Maryland Cremation Services
PO Box 1413, Baltimore, MD Signature of Funeral Service Licensee Dorota Marshall Maistra 11 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Respiratory disease or condition inichown Medical resulting in death) Due to () as a consequence of) **Examiner** cancer (Stage IV) unknown Metastatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ 1 ☐ Live Birth 2 ☐ Fetal dea:
4 ☐ Pregnant at time of death
9 ☐ Unknown in the past 12 months? Month Dav Year Ves 2 Win 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of CHRONIC Obstructive Pulmonary Disease 24a. Was an autopsy death? Hepatitis C 2 1 No 1 Tyes Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ☑ No Other: မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 Natural injury 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar

NHMH 17 Rev 7/2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Jennifer Thomas 3001 S. Hanover Street, Baltimore, MP 21225 . Registrar's Signature

thomas i MD

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

November 10,2011

29c. License number

Res 001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 30 AM **Physician** 2011 Donald Watson OV. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSPITAL AGNES If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
June 23,1923 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 □ F 88 Yrs. 273-20-7546 Ohio Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show r 28a-f show notified at 1 ☐ Yes 2 XNo Director Catonsville Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or the Medical Examiner must be 1 6132 Wheatland Road 21228 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify. Specify: White þ 3 Midowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dental Technician 10 permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygis Important: If item 27 is marked other any Injury or other traumatic event, the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Albert Watson Josie Edith Stethem 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6132 Wheatland Road; Catonsville, MD 21228 Francis Watson Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest VA Cem 11/22/20114 □ Donation 5 □ Other (Specify) Owings Mills, MD 22. Name and Address of Facility terling Ashton Schwab Witzke 21. Si at re of Funeral Service Licen Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville MD 21228 Approximate Interval Between Onset and Death 23a. Part Enter the disease, of complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ANTERIOR NFARCTION **Physician** ACUTE /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner severe attending physician and for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ page 2 should be 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an performe death?
1 ☐ Yes ARKINSON A 2 No certificate 2 **P** No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ပ 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? To the Funeral Director: After completely filled in by the funera (Month, Day Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ō To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier COVERING ATTENDIN D16200 of death (Item 23a) (Type, Print) 7206 MAIDEN Choice LA., CATONS VILLE, NO 21228 M. MACHIR

State Registrar

Registrar DHMH 17 Rev 06-2011

State

(Check only one)

29b. Signature and tile of ce

JACKIE

31. Date filed (Month, Day, Year)

JONES

CRNP

2300 DULANEY VALLEY RD.

person who completed cause of death (Item 23a) (Type, Print)

3 🕱 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

TIMONIUM.

MD 21093

29d. Date signed (Mgnth, Day, Year)

11-08287 David Anthony W	alk		or Print in B e of Maryland						egible		1 2661
		- For State Registrar		•		of Death	-		Reg. No.		1 3661
Physicia Medical Examin	10	1. Decedent's Name (First, Middle, L David Anthon	y Walker					2. Date of De Month Novemb	Day er 4, 2		3. Time of Death 2254 hrs
\bigcirc		4a. Facility Name (if not institution, 57 Shipping Place #A19)		4b. City, Town, o Dundalk	or Location of	Death		e. County of Deatl Baltimore Cou	
Funeral Director		,		ge (In yrs. last t		If Under 1 Ye Months Da		24Hrs. 8. Date of I		Co	thplace (State or Foreign ountry)
		Usual Residence of Decedent	X M 2 F		Yı			10/2	7/13	700 Ge	rmany 10d. Inside City Limits
nd show any acc.	٦	MD Balti	more	10c. City, Tov	nda]						1 Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 57 Shipping P	lace #A´	19		10f. Zip Code	222		10g. Cit	izen of What Cou	ntry?
th with the ems 23a	Funeral	11. Marital Status 1 X Never Married 2 Marri	12. Was Deceden	t Ever in U.S.		/as Decedent of H	lispanic Origin	n? (Specify Yes or I Puerto Rican, etc.)	No-		ican Indian, Black,
after dea	by Fur		1 X Yes 2	No	1	Yes 2 X N				Specify: W	hite
2 hours.		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade co			ent's Usual Decup most of working lif			16b.	Kind of Business/	Industry
5-0036 led within 7 Hygiene. to ther than	Completed	12yrs 17. Father's Name (First, Middle, La	set\		Ca	ab Driv		Name (First, Middle		Driver	
21215- nuld be filed Mental Hyg marked of	Be	Lawerence Wa	lker				Sara	h Poole		,	
MD 2. d 2 should the and M a 27 is m.	입	19a. Informant's Name/Relationship Robert L. Wal		1.0				per or Rural Route N Middle			
MOTE, Pages and ent of Heal aut: If item		20a. Method of Disposition 1 Burial 2 X Cremation	3 Removal from S	tate crem	natory or c	osition (Name of control of contr	- 1	Date 11/12/11		Location - City or	
Caltim	ł	4 Donation 5 Other Spec 21. Signature of Funeral Service Lic		ACI	22.	Name and Addre	ss of Facility	Simplici	ity	Crem &	Fun Serv
M	-	23a. Part I. Enter the disease, or co		the death, Do							nover MD Approximate Interval
/Medical Examiner	ì	failure. List only one cause on Immediate Cause (Final disease or condition resulting in death)	a. Heroin and Cod		cation						Between Onset and Death
	إ	Sequentially list conditions,	b.								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inhibited	Due to (or as a cons c.				17				
/20 g g E .	g Ex	events resulting in death) Last	d								
760, ficate be exe g physician : the burial -	Wed	UNPENDED F FEMALE:	AMENDED 23c. If yes, outco	me of pregnan	су				23	d. Date of deliver	у
Box 68760, e death certificate be the attending physic ed for use as the burner.	Physician/Medi	3b. Was decedent pregnant in the past 12 months?		t time of death	- =	etal death 3 Other (Specify)	Ectopic	pregnancy		Month	Day Year
D. Bo. t the deat by the at ached for		1 Yes 2 No 9 Unkno	9 Ulknown	th but not resul	ting in the	underlying cause	given in Part	11. 23e. Dio	tobacco	use contribute to	the cause of death?
S, P.O. luires that the signed by a lid be detach.	ed by										bably 4 Unknown
e Cords, e law requir e has been s	Completed					-		per	opsy formed?	prior to death?	utopsy findings available completion of cause of
ital Rec ician: The l certificate i	S B B	25. Was case referred to medical examiner?	Hospital: 1 Inpati				·Othor —	Check only one)	_		
Division of Vital Records, ral or Attending Physician: The law requinras after death. ral Director: After this certificate has been si lied in by the funeral director, page 2 should the	의	1 Yes 2 No 27. Manner of Death	28a. Date of Inj. FOUND:	128	Outpatier Time of		Other ₄	Nursing Home 5 28d. Describ Unknown		ence 6 🗹 Othe	r: Scene
ision Attendi er death. rector: /	Certification:	1 Natural 5 Pending 2 Accident Investig	Nov 4, 2011	22	OUND: 27 hrs farm, stre	eet, factory, office	Yes 2 1	No I	(Street	and Number or R	ural Route Number, City
Div spital or hours aftu neral Di		3 Suicide 6 ✓ Could n 4 Homicide 29a. Certifier ← Could n	ot be					or Town	State)	#A19, Dundalk,	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial.	Medical	(Check only 1 Certifying Phys	ician: To the best of mer: Dn the basis of exa and manner stated.								
H s H o	ž	29b. Signature and title of certified	1				se number			Date signed (Movember 5, 20	
OCME	}	30. Name and addless of person wr			,			Dolling and 145			-
Sta	ite	Mary G. Ripple MD. D	peputy Chief Medi	cal Examin		0 W. Baltimor	re Street, I	Baltimore, MD :	21223		-
Registr	ar	MATA	CUII LENIN	الر سه	7						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36615 1 - State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 13, 2011 2:25 a^M November Thomas Dorsey Welsh Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Hospice Center Towson If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 215-32-9796 **Director** 73 1 X M 2 F Aug 26, 1938 Maryland Usual Residence of Deced 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified MD Baltimore Parkville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or must be Funeral 14 Ranger Court 21234 U.S.A. Page 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. þ 1 Never Married 2 Married 2 No X Yes Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify 3 Widowed 4 🙀 Divorced Specify. Completed White Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working alth and Mental Hygiene.
27 is marked other than r traumatic event, the M. Elementary/Secondary (0-12) College (1-4 or 5+ 12 State of Maryland Maintenance Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ Welsh Walter Helen. Grove 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Ranger Court Parkville, Maryland Smith Daughter Kathy other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 🖾 Burial 2 🗴 Cremation 3 🗆 Removal from State ÷ 9 Department of Important: If any injury or 4 Donation 5 Other (Specify) 11/15/11 Carroll Cremation Hampstead, Maryland Signature of Euneral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Se uns ELINE FUNERAL HOME Reisterstown, MD 7.en 21136 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nterval Between Onset and Death Immediate Cause (Final Physician/ Metastatic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami burial-tran resulting in death) Last Due to (or as a consequence of): physician Physician/Medical The law requires that the death certificate be P.O. Box 68760 the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 2 🗌 No Yes 2 🔽 1 🗌 Yes Division of Vital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) _ H → S () 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at 24 hours after death. Funeral Director: After 1 Natural 5 Pending 1 Tyes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one)

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

4105 ARATHI KUMAR 6701 NO HARIES ST SULTE RALTIMORIZMO 32. Registra s Signa

71040

29d. Date signed (Month, Day, Year)

Registrar

		-	_ State	State of Maryla	nd / Depa <i>Cer</i>	artment of H tificate of D	ealth and iv <i>eath</i>		giene 20 Reg. No.	111 36616					
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	Funeral Director		5. Social Security Number 6. Sex 1 □ N	7. Age (In yrs		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	h y, Year)	Birthplace (State or Foreign Country)					
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920	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fedical Examiner must be notified at	ed by	3 ☒ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates.		I ☐ Yes 2 X No	Specify:		Specify	WHITE					
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Baltimore,	t. Pag tmen rtant:		4 Donation 5 Other (Specify)			OF DAVID		3/2011		H LAUDERDALE, FL BROS., INC.					
Ba	Depar Depar Impo any ir once.		21. Signature of Funeral Service License	Ugen						LLE, MD 21208					
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director After this certifical completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physicia (Check 2 Medical Examiner	in: To the best of my kn	owledge, death	occurred at the time	e, date and place, a	and due to the o	cause(s) and mai	nner as stated. due to the cause(s) and manner stated.					
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	フ ^v Sta	te.	31. Date filed (Month, Day, Year)	32. Register's Sig	DIZI MI	MI ROSE (7 100	A / A 1 guer (7	-0002					
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	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral I	4503 Duncan Drive 22003 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-									it Country?		
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1	within 24 hours after death. To the Funeral Director, After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detach.	Medical	29a. Certifier 1 X Certifying Physician: To the beautiful Check 2 Medical Examiner: On the basi	s of examination a	and/or investi	gation, in my opinio	n, death occ	curred at th	ne time, date a	nd place	and due to the	cause(s) and manner stated.
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	10+1		1 N. Robert pinos	Who	here		D C)4115		0 ct o	ber 29,	2011
			30. Name and address of person who completed cause									
	State		H. Robert Birschbach, M 31. Date filed (Month, Day, Year)	.D. 201		ell Avenu	ie, Ga	aithe	rsburg	, MD	20877	
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Sr. Willie 2011 October 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Crisfield Somerset McCraidy HOSPita If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Months 1**万**M 2□F 214-28-8345 13 1929 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 1**Y**iYes 2 □ No Cristield Somerset Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21817 U.S. A. Somer-s 14. Bace - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give / Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: Black 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sea food Industr abover 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Freddie Agnes Johnson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) - Daughter 44 Somers Cove Apts, Crisfield, MD, 121817 Μ. Shelia Ames 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 5/11 Marion Station MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of puneral Service Licensee 22. Name and Address o Facility Anthony E Princess 30639 Hampden, MD, 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dissifu for es e nonsociianno (f) Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 □Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Physician /Medical Examiner Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

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Completed

Be

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ortant; If item 27 Is marked other than "natural", or items 23a or 28a-f sh injury or other traumatic event, <u>the Medical Examiner must be notified</u>

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traummit.

3altimore, Maryland 21215-0036

burial-transi the SIS for use

requires that the death certificate be executed

Box 68760,

P.0.

Division or Vital Records,

physician attending ate has been signed by the a page 2 should be detached certificate funeral director, within 24 hours after death.

To the Funeral Director: After this

Physician/Medical ģ Completed Be 2

1 Tes

27. Manner of Death

1. Natural

2 Accident

3 ☐ Suicide

4 Homicide

2 No

Certification:

To the Hospital or Attending Physician; completely filled in by the IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

5 ☐ Pending investigation

6 Could not be determined

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? Date of Injury (Month, Day Year) 28d. Describe how injury occurred Injury

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

31. Date filed (Month

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Aleen Amberg November 1204 Рм Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Calvert Manor Healthcare Center Rising Sun Ceci1 If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 😿 F 0CT 2T. 1917 Months Days Hours Min. North Carolina Director 238-12-2895 94 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 4005 Blue Ball Road 21921 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11 Marital Status Armed Forces
1 X Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 Married þ 2 No 1 ☐ Yes 2 🗓 No Specify: White 3 X Widowed 4 ☐ Divorced Completed 1943 Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Homemaker In Her Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental Important: If item 27 is marked o any injury or other traumatics. ပ Charles McLamb Florence Royals 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph G. Amberg/Son 4005 Blue Ball Road, Elkton, MD 21921 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 9 1 ☐ Burial 2 🗓 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) A. Ferris & Co., Inc. West Chester, PA 2011 22. Name and Address of Facility Hicks Home for Funerals, P.A. ure of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): and -transit Exami death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician ator use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death signed by the a d be detached f 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director; After this certificate has be autopsv 1 ☐ Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 2.XNo Hospital: မ 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury within 24 hours after death.

To the Funeral Director, Af completed filled in by the fu 2√2 No 2 Accident Investigation 1 Tes 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 \square Homicide determined Medical

Registrar DHMH 17 Rev 7/2009 29a. Certifier

(Check

only one) 29b. Signature and title

30. Name and address

NOV

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of person who completed cause o

32. Registrar

Baltimore, Maryland 21215-0036

68760

Box (

Records,

Division of Vital

(Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36621 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 22 Day 2011 Year $\Pi\Pi^{\mathsf{opth}}_{\mathbf{Y}}$ VIRGINIA HARRIS BAILEY 2110 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death CHESTER RIVER HOSPITAL CENTER **CHESTERTOWN** KENT 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Days Min 219-07-6599 95 3719/1916 Director MARYLAND Usual Residence of Decedent 28a-f show 10a. State 10h County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND QUEEN ANNE'S 1 ▼ Yes 2 □ No CHURCH HILL 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 530 MAIN STREET 21623 USA "natural", or items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 hours after 1 Yes 2 No Specify: 3 XWidowed 4 ☐ Divorced Completed Specify: WHITE Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) within 72 permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WRIGHT P. HARRIS REBA CHANCE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFFREY THOMPSON / ATTORNEY 124 COMMERCE STRET CENTREVILLE, MD 21617 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Nurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHURCH HILL CEMETERY 7/28/11 CHURCH HILL, MD Signature of Funeral Service Licensee 22. Name and Address of Facility CHESTERTOWN, MARYLAND 21620 <u> †ELLOWS, HELFENBEIN,</u> NEWNAM 130 SPEER ROAD 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only o that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Interval Between Immediate Cause (Final Onset and Death Physician/ PNEUN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or impury that initiated events the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 1 Live Birth
4 Pregnant a
9 Unknown in the past 12 months?

1 Yes 2 No been signed by the atte should be detached for Year Day Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 No 3 Probably 4 Onknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has perform After this certificate 2 D No Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: ျ 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending ☐ Accident ☐ Suicide 1 ☐ Yes 2 ☐ No Investigation after death 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check within 2 To the F 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 2011 71130 1)00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) en (Oftes, 270m BROW 21620 100

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

/Medical Examiner Division of Vital Records, P.O. Box 68760.

to the Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-trar attending physician for use as the buria use as s been signed by the should be detached funeral director, After this filled in by the

Examiner

Physician

/Medical

Examiner

Director

Funeral

Completed

Be

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Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modess Examinar transition rollified at

altimore, Maryland 21215-0036

1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than '

permit. Pages 1 and 2.
Department of Health a Important: If item 27 is any Injury or other trauonce.

Physician

within 24 hours after death To the Funeral Director:

Physician/Medical \$ Completed Be Certification: To Medical

29a, Certifier

(Check only one) 29b. Signature and title of

2

State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SYEハ

TOCK HOUSE, FREDERICK, MD

32. Registrar's Signature 31. Date filed (Monti

Passera .

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene 36623 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2011 Richard Brown, Jr. рМ October 8:15 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Manor Care - Silver Spring Silver Spring Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 455-54-0953 79 1**X** M 2 □ F 08/07/1932 Texas Usual Residence of Deced 28a-f show 10a, State 10c. City, Town or Location notified at 10d. Inside City Limits Director MD Howard Columbia 1 🗆 Yes 2 🏲 No 10e Street and Number ō 10f. Zip Code 10g, Citizen of What Country? ems 23a or Funeral 6526 River Run 21044 United States ed other than "natural", or items event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 **X** No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. ş 1 X Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: 3 Widowed 4 Divorced Specify: Completed Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other th Farmer Rice Farming Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Richard Brown Lorell Mendus 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris A. Genus - sister 6526 River Run Columbia, MD 21044 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Columbia Mem. Park 4 Donation 5 Other (Specify) 11/02/2011 Clarksville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. Collis 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death 24 hrs Immediate Cause (Final Physician/ Myocardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Hypertension vears Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Exami iding physician and use as the burial-trar Due to (or as a consequence of): Physician/Medical death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? ☐ Live Birth ∠ ☐ 1 Star 2 ☐
☐ Pregnant at time of death
☐ Unknown fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>8</u> Arthritis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Yes 2 X No Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 XNursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 20 Accident 5 Pending s after death.

I Director: Aft

d in by the fur 1 Yes 2 🗌 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined filled in City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one)

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

State Registrar

29b. Signature and title of certifier

10910 Darnestown Road Suite 202 Raman Tuli, MD 31. Date filed (Month Nov Year) 2 2011 Registrar's Signature

30. Name and address of person who completed cause of death (tern 23a) (Type, Print)

Gaithersburg, MD 20878

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death Physician/ Day of De tober 6:10 AM 2011 Medical Flemina Boswell James 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day; If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** Days Hours 242-84-4824 County C. Director 1 🛮 M 2 □ F 61 03/28/1950 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location must be notified at 10d. Inside City Limits **Funeral Director** Md. District Heights 1X Yes 2 □ No Prince Georges 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? items 23a 2912 Sydney Avenue 20747 U. S. A. "natural", or item ledical Examiner n 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify.Black 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Year or Dates Health and Mental Hygiene. tem 27 is marked other than "natul other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Men's Clothing <u>Sales_Associate</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Fleming Boswell Ressie Inez Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shayron Simmons 2912 Sydney Avenue District Heights, Md. 20747 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Family Cenetery 11/10/2011 Burlington, N.C. 21. Signature of Figheral Service Line 22. Name and Address of Facility W. H. Bacon Funeral Home, 3447 14th Street, NW Washi Inc. Washington, 23a. Part 1. Enter the disease, or complications that coased the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ Circulator disease or condition Medical resulting in death) **Examiner** Cardiac MUCH Sequentially list conditions, if any, making to intraction cause. Enter Underlying Physician/Medical Examine Due to for each co sician and burial-transit Ye an Cause (Disease or injury that initiated events Condianyon Due to (or as a consequence of resulting in death) Last attending physician I for use as the buria Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) signed by the atte in the past 12 months? Month Dav Year 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Chronic Kidney 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed Yes 2 No 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 XNo Hospital Other: မြ 1) Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) October 315t 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Michael 12150 Annapolis Rd Glenn Dale Ste ZOO 20769 State

DHMH 17 Rev 06-2011

Registrar

NOV 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10/52%5077 23:29 PM Georgia A. Bass Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Southern Maryland Hospital Clinton 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Hours **Director** 194-28-8376 1 🗆 M 2 🗶 F 79 77/52/7437 NC Usual Residence of Decede 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 X Yes 2 □ No MD Prince Georges Temple Hills 10e. Street and Number ō 10g. Citizen of What Country? an "natural", or items 23a or Medical Examiner must be Funeral 5504 Charlotte Dr. 20748 AZU 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: Black 3 Widowed 4 Noivorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7? Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4 or 5+) 4 Librarian Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lula Sherrill Charles Armstrong 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna L. Hobbs / daughter 8600 Adios St., Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Chesapeake Crematory 1//07/2011 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa ure o Funeral Service Lic 1 22. Name and Address of Facility Strickland Funeral Services Allentown Rd., Camp Springs, MD 2074A Fart 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) 104-d Medical Due to (or a consequence of): Examiner Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Exami and I-transit executed that initiated events resulting in death) Last Due to (or as a consequence of): ed by the attending physician a detached for use as the burial-Physician/Medical The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No
9 Unknown Month Dav Year Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes **Division of Vital** or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 🛮 No Other: ျပ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending neral Director: A rilled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after Hospital 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completely fi 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 10/20111 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State

Registrar

NOV 0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 36626 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 1429 Marvin James Brown 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death MEMORIAL EASTON TALBOT HOSPITAL AT EASTON Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Hours 220-32-7825 **Director** 75 1 X M 2 □ F July 3 1936 Maryland Usual Residence of Decedent or 28a-f show notified at 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 💢 No Maryland Caroline Preston 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? , or items 23a or iminer must be r Funeral 24218 Mellow Drive 21655 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black, White, etc. 1 X Never Married 2 Married Completed by Yes 21215-0036 Black 1 ☐ Yes 2 X No Specify: If Yes. Give 3 Widowed 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) truck driver refuge industry Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clifton Brown Emma Lou Hoxter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Latricia Downes/ 24218 Mellow Drive; Preston, MD 21655 Department of Health Important: If item 27 any injury or other tr daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) New Union Church Cm Oct. 29, 2011 Goldsboro, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 Fleegle and Helfenbein Funeral Home, PA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 1 🗌 Yes 2 No Other: 1 Inpatient 2 XER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director: Suicide
Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 10056873 who completed cause of de ath (Kern 23a) (Type, Print) 314 RAILROAD AVE P.D. By 122 Goldshop, MD 21636 KARNES-AMZIBEL 061, . Registrar's Signa State

DHMH 17 Rev 06-2011

Registrar

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MARV.R

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 36627 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death BiaLCZAK Physician/ Month Marguerite 9:20 AM Dawne November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours 2/26/1957 Country) 217-72-6594 54 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important. If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Delta PA York 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 17314 36 Forest Trail USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No 1 Never Married 2 Married If Yes, Give 1 Yes 2 No Specify: White 3√Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Food Services Chef Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Shirlee Gentile Anthony Bialczak 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jack L. Lopez/Companion 36 Forest Trail, Delta, PA20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 X Cremation 3X Removal from State 4 Donation 5 Other (Specify) Evans Eagle Crem. 11/9/11 Leola, PA 21. Signature of Turieral Service 22. Name and Address of Facility · Kobert Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Squamus Cell Corcinomy Physician/ Due to (or as a con quence of): Circhosis iver Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Buenmoura that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death 1 Yes 2 S Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? Completed by Hepatitis 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\text{Yes} \) 2 \(\text{No} \) No 24a. Was an 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 \(\sum \) Yes 2 \(\sum \) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at

- Medical Examiner use as the burial-transit and signed by the attending physician defacted for use as the burial Division of Vital Records, P.O. Box 68760 After this certificate has Phospital or Attending Physician: 24 hours after death.
Funeral Director; After this certific To the Hospital or Attendii within 24 hours after death.

To the Funeral Director, At completed filled in by the fu

28a-f show

Baltimore, Maryland 21215-0036

Medical

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 063653 November 8, 2011

work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

City or Town, State)

28f. Location (Street and Number or Rural Route Number,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Evons

UPPER Chesapeake Drive Bel Air , MD 21014 500

iniury

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Natural

Accident

Suicide

4 Homicide

29a. Certifier

(Check

5 Pending

Investigation

determined

6 Could not be

			For State	State of Marylan		irtment of H tificate of D			/ 1		36628		
	Db	/	Registrar 1. Decedent's Name (First, Middle, Lass	()		imoute of B	Outri	2. Date of Death	g. No.		3. Time of Death		
al many	Physicia Medio	al	George E. Crider					October			11:44 AM		
7	Examin	er	4a. Facility Name (if not institution, give			4b. City, Town, or			4c. County of Death				
-11	Funeral		Holy Cross Hospit 5. Social Security Number 6. Se		st birthday)	Silver S If Under 1 Year Months Days		8. Date of Birth		g. Birthp Count	lace (State or Foreign		
	Director		277–40–2182 Usual Residence of Decedent	X M 2 □ F 67	Yrs.	Months	Hours Will.	(Month, Day, Y		Kentu	"_		
	and show l at	or	10a. State 10b. County	10c, City	, Town or Loc	ation			10d. Inside City Limits				
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	th the 3a or t be n	ralD	10e. Street and Number			10f. Zip Code			g. Citizen of		1		
	ems 2	Funeral Director	8101 Ryda1 Road	12. Was Decedent Ever in U.S		20747 Vas Decedent of His		ecify Yes or No-	nited 14. Rad	state ce - America			
စ္က	fter de , or it amine	by	1 Never Married 2 Married	Armed Forces? 1 Yes 2 □ No If Yes, Give		Yes, specify Cubar ☐ Yes 2 No		Rican, etc.)	Bla	ck, White, e	etc.		
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and	be filed within 72 hours after death with the Maryland ental Hygiene. 'ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)					ne (First, Middle, Ma	iden Surnam	e)			
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nand Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		George E. Crider 19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailin		Annie Ma	e Brown_ al Route Number, C	ity or Town,	State, Zip C	Code)		
	1 and 2 should be if Health and Men item 27 is marke other traumatic		Jocelyn Crider/Wit	Te	T			tville, l					
Baltimore,	ge 1 ar it of He If iter or oth		20a. Method of Disposition 1 X Burial 2 Cremation 3		lace of Disposemetery, crem	sition (Name of natory or other place	e)	Date 2	0c. Location	- City or To	wn, State		
<u>=</u>	permit. Page Department Important: I any injury o	- 25	4 Donation 5 Other (Specifical Signature of Funeral Service) Licens	RCS				/2011 C uire Func					
Ba	permit. Page 1 a Department of H Important: If ite any injury or oth	8	• Alero Maxin	nt	74	00 Georgi	la Avenue District	North Wood	est mbia 2	0012	e, Inc.		
			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	olications that caused the death							Approximate Interval Between		
	Physician/		Immediate Cause (Final disease or condition	a. Myocardial		tion					Onset and Death		
	Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):								
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or at a done-equ	lence ci <i>j</i> :	-							
	cuted ind	Examiner	Cause (Disease or injury that initiated events	c									
	ate be executed physician and the burial-	dical E	resulting in death) Last	Due to (or as a consequ	ierice oi).								
3760	certificate be executed nding physician and use as the burial-basi	I O	IE FEMALE:	a									
89 x	requires that the death certific. been signed by the attending Isshould be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 Live Birth 2 Feta	ıl death 3 🗌		у			ate of delive	ery Day Year		
. Box	that the death ned by the atte e detached for	ysic	1 Yes 2 No	4 ☐ Pregnant at time of c 9 ☐ Unknown	leath 5∟	Other (specify)			I IVI	onun	Day Teal		
P.0.	that the	by Pr	Part II. Other significant conditions co	ontributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.	23e. Did toba	acco use con	tribute to th	ne cause of death?		
ds,	quires en sig ould b	ted k						1 🗆 Yes	2 🗆 No	3 Prot	bably 4 🖺 Unknown		
COL	law re has be le 2 sh	Completed						24a. Was an autopsy		Were autop prior to co death?	psy findings available mpletion of cause of		
R	sician: The law certificate has k lirector, page 2 s		25. Was case referred to medical			OC DIA	and of Dooth /Char	perform	No	1 Yes	2 🗌 No		
Vita V	ysician: is certific director,	To Be	evaminer?	Hospital:	ER/Outpatien	Othe	ace of Death (Checer: 4 Nursing H	ome 5 Resider	nce 6 🗆 Otl	ner (Specify	·)		
10	ding Phys th. After this funeral di		27. Manner of Death 1 X Natural 5 Pending	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury work	at ?	28d. Describe how					
sior	II or Attendi after death Director; A d in by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be		me, farm, stre		Yes 2 No	28f. Location (Stre	et and Numi	ner or Rural	Route Number		
Division of Vital Records,	al or A s after al Dire		4 ☐ Homicide determined	building, etc. (Specify		, , , , , , , , , , , , , , , , , , , ,		City or Town,		301 07 714741	riodio riarisos,		
_	To the Hospital or Attending Physician: The law requires within 24 hours after death. To the Funeral Director: After this certificate has been sign completely filled in by the funeral director, page 2 should be	Medical	29a, Certifier 1 Certifying Physics (Check 2 Medical Exami	sician: To the best of my knowl ner: On the basis of examination	ledge, death on and/or invest	occurred at the time	e, date and place, a	and due to the caus at the time, date and	se(s) and mar place, and d	ner as state	ed. use(s) and manner stated.		
	o the o the o the o the o the omple	ž	only one) 3 Certifying Nurs 29b. Signature and title of certifier	se Practitioner: To the best of n	ny knowledge,	death occurred at ti			cause(s) and				
	5-5-	+1	160	X		D6257	71		ctober				
	7		30. Name and address of person who c			rint)				-			
	Sta	te.	Dr. Sarah Bromela: 31. Date filed (Month, Day, Year)	# 22 Pogistraria Signat	huro e		ilver Spi	ring,Mary	land 2	0910			
	Registr		NOV 0 1 2011	Senter A.	park								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registra 36629 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Maxwell George Christopher 2011 October 3:50 A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Gaithersburg 25 Cedar Avenue 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Days Hours (Month, Day, Ye March 19 1 X M 2 D F Months Min Director Washington, DC 229-46-0058 74 Usual Residence of Decedent 28a-f show items 23a or 28a-f sho ner must be notified at 10c, City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20877 United States 25 Cedar Avenue be filed within 72 hours after death antal Hygiene. Ked other than "natural", or item: ic event, the Medical Examiner m 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No 1960-Black, White, etc 2 1 Never Married 2 X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed Year or Dates. 1964 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Oceanic and Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Engineer Atmospheric Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be file h and Mental | 7 is marked o မ Maxwell G. Christopher Morris Thelma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl nt of Health a : If item 27 is Patricia M. Christopher/Spouse 25 Cedar Avenue, Gaithersburg, MD 20877 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it any injury or or 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) 10/29/2011 Alexandria, VA Metropolitan Crem. . Signature of Funeral Service Licensee 22. Name and Address of Facility ME Million DeVol Funeral Home 10 E. Deer Park Drive, Gaithersburg, MD 20877 MO1202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Lung Cancer disease or condition resulting in death) Year Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Disease or injury Due to (or as a consequence of) death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician a Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atter for u in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 X Residence 6 Other (Specify, funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined

Box 68760 P.O. Records, Division of Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: Al filled in by npleted

To the I within 2. To the F complet 30+ Medical

29a. Certifier

3

Joseph M. Haggerty,

NOV 01

Goseph M. Haggerty MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

ORIGINAL

🕱 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D32407

MD, 9707 Medical Center Drive #300, Rockville, MD 20850

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

City or Town, State)

29d. Date signed (Month, Day, Year)

October 29, 2011

	For State	Plea	ase Type or State of		nd / Dep	artment of	Health	and N	-		-egible. 2∩ I	36630
ysician/	Registrar 1. Decedent's Name		•	Chan -		rtificate of	Deam		2. Date of De	Dav	Year	3. Time of Death
Medical kaminer	4a. Facility Name (if		ying , give street and nur	Chao - (Chen	4b. City, Town,	or Location	n of Death	0ctobe	4c. Co	2011 ounty of Deat	3:35p M
eral ctor	Carroll F 5. Social Security N 219-64-71	umber	6. Sex 1 \(\text{M} \) 1 \(\text{N} \) F	7. Age (In yrs	: last birthday) Yrs.	Westmin If Under 1 Year Months Days	If Und	er 24 Hrs. Min.	8. Date of Bir (Month, Da		9. Birt	hplace (State or Foreign
	Usual Residence of 10a. State				City, Town or Lo	cation		July 1			10d. Inside City Limits	
be notified at	VA 10e. Street and Nun	Fair	fax		Annandale	10f. Zip Code				10g. Citize	en of What Co	1 ☐ Yes 2 🚨 No untry?
any injury or other traumatic event, the medical Examiner must be notified at once. To Be Completed by Funeral Director	6834 Colu 11. Marital Status 1 Never Marr 3 X Widowed	ied 2 □ Mar	12. Was Decr	2 🛛 No ve		22003 Was Decedent of If Yes, specify Cub	an, Mexic	an, Puerto	ecify Yes or No- Rican, etc.)	14	S. A. Race - Amer Black, White	
Completed	(Spe Elementary/Seco	cify only high	nt's Education est grade completed College (1)	16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Homemaker Own I							Industry
To Be	17. Father's Name (i		Last)		<u> </u>			ther's Nam	e (First, Middle, Jin	Maiden Sui	rname)	
omer traum	19a. Informant's Na James Sha 20a. Method of Disp	aw - S	hip (Type, Print)	20b	683	ng Address (Stree 34 Columbia position (Name of		, Anna		rginia		
y injury or ce.	1 XBurial 2 4 ☐ Donation 21. Signature of Fur	5 Other (State	cemetery, crea	matory or other pla Memorial F 2. Name and Addr	ark	11/5	/2011			ch, Virginia
he burial-transity upon less than the burial-transity and less than the burial transity and the burial-transity and the burial	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Linterval Betw Onset and D Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										Approximate Interval Between Onset and Death	
stached for use as the bu Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 r 9 ☐ Unknown	months?		Birth 2 🗍 Fo	etal death 3 [Ectopic pregnar Other (specify)	псу			23	d. Date of del Month	livery Day Year
d by	Part II. Other signif	icant condition	ons contributing to c	leath but not r	esulting in the I	underlying cause o	iven in Pa	rt I.	i			the cause of death?
Completed											prior to death?	topsy findings available completion of cause of
Medical Certificate: To Be Completed	25. Was case referre examiner? 1 Yes 2 27. Manner of Death Accident	K No	28a. Date (Mon		ER/Outpatie 28b. Time o injury	nt 3 DOA Ot 28c. Inju	her: 4 🗆 ıry at	Nursing Ho	k only one) ome 5 Resi 28d. Describe l			ify)
al Certif	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	ined 28e. Place	of Injury - At ing, etc. (Spec		eet, factory, office			28f. Location (Number or Ru	ral Route Number,
Medical		Certifying	Nurse Practioner:	sis of examinat	ion and/or inves	tigation, in my opin death occurred at t 29c. Licen	ion, death he time, da se number	occurred a ate and place	t the time, date a ce, and due to the	and place, and place, and place, and place, and	nd due to the o and manner as signed (Month	cause(s) and manner stated stated.
State gistrar	30. Name and addre	MA	+UMUUD 12. F	se of death (Ite	Ridge	Print) Ranc	372 (v	5 Ves	fmin	skr	1/28 M	10 21157

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36631 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 2011 5:20P Sally Ann Cassidy Medical a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death TALBOT 28638 HOPE CIRCLE **EASTON** Social Security Number 9. Birthplace (State or Foreign Country) . C . 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** (Month, Day, Year) Months Days Hours Min 1 M 2 XF 579-34-8498 81 Director Aug. Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location 10d. Inside City Limits Director Talbot 1 Tes 2 No MD Easton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 28638 Hope Circle USA 21601 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black. White, etc. 1 Never Married 2 Married þ If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mentai Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 은 James St. Clair Gardiner Catherine Murray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alan Cassidy/Husband 28638 Hope Circle, Easton, MD 21601 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) $^{N}2811^{3}$ 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, MD Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 21. Signature of Funeral Service Licenses 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ ASPITATION disease or condition 2 weller Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examin Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the butatrar Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months
1 ☐ Yes 2 ☐ No Month Year signed by the at d be detached for ☐ Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy his certificate hil director, page performed^a death? 2 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes Other: ပ 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Accident Suicide 1 🗌 Yes 2 No Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. the Funeral Director: After this or mpleted filled in by the funeral dir within 2.

CASS1

31. Date filed (Month, Day, Year, State NOV 0 1 2011 Registrar

30. Name and address of person who

29b. Signature and title of certifier

only one)

LUDWIG J. EGLSEDER, III, MD 503 CYNWOOD DRIVE, EASTON, MD 32. Registrar's Signature

empleted cause of death (Item 23a) (Type, Print)

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

21601

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36632 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ TO 201^{Year} 26^{bay} Harold 10:57 AM Edwin Caliver Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Silver Spring Holy Cross Hospital 8. Date of Birth (Month, Day, Year) Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 277-34-2055 Director 1 X M 2 □ F 72 OH 02/14/1939 Usual Residence of Dece show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryland aţ Director notified 28a-f 1X Yes 2 ☐ No MD Silver Spring Montgomery 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral death with 2606 Nisqually Court 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ıral", or iten I Exa⊞iner ı Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married þ Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black "natural" Completed 3 Widowed 4 Divorced Year or Dates unknown Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Truck Driver Waste Manager 10 of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earl Caliver, Sr Dorothy Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Bernice S. Caliver/Wife 2606 Nisqually Ct. Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 9 Department of Important: If any injury or once, Holy Baptist Chur. 11/05/2011 | Unionville, VA 4 ☐ Donation 5 ☐ Other (Specify) Mt. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Marshall-March Funeral Home Henet C Anderson 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Mycardial Infarction disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Cardiovascular Disease 10 years Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying Dire to (or as a consequence of) attending physician an I for use as the burial-trene Cause (Disease or injury that initiated events 20 years Diabetes Due to (or as a consequence of): resulting in death) Last Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year 5 Other (specify) signed by the at d be detached for Pregnant at time of death 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hypertension 1 Yes 2 No 3 Probably 4 X Unknown pluods Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Renal Failure 24a. Was an has page 2 autopsy performe certificate ☐ Yes 2 🛛 No 1 Yes 2 🔀 No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည ER/Outpatient 3 DOA 1X Inpatient 2 □ 27. Manner of Death 28a. Date of injury (Month, Day, Year)

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific

Certificate: pletely filled in by the

Medical

Natural

2 Accident

3 Suicide 4 Homicide

29b. Signature

31. Date filed (Month, Day, Year,

State Registrar

14

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 3

5 Pending

Investigation 6 Could not be

determined

D21153

29c. License number

28c. Injury at

work? 1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

. Location (Street and Number or Rural Route Number, City or Town, State)

10/26/2011

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gary D. Ruben, MD 11120 New Hampshire Avenue Silver Spring, MD 20904

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

NOV 0 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36633 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 28 20II BERNADETTE MARIE CLARK 3:33 A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK If Under 1 Year If Under 24 Hrs
Months Davs Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 31, 1959 Funeral 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🎮 Months Maryland Director 52 217-48-6963 Jan. Usual Residence of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Frederick Frederick 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 434 Shannon Court 21701 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? Black. White, etc. 9 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ☐ Yes If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural" Specify: 3 Divorced 4 Divorced White traumatic event, the Medical 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d Mental Hygiene. marked other than Frederick County Elementary/Seconday (0-12) College (1-4 or 5+) Board of Education Bookkeeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilson Troxell Marlene Funk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Department of Health Important: If item 27 any injury or other tr Germaine L. Crocker / Sister 208 Sunrise Court, Altoona Pennsylvania 16601 2Cb. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery 11/1/2011 Frederick, Maryland. 21. Signature of Eureral Service 22. Name and Address of Facility Stauffer Funeral Homes P. A. 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one call hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ tumonaru disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine or as a consequence of cause. Enter Underlying Cause (Disease or iinjury the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year 2 No the a 1 ☐ Yes ∠ y 9 ☐ Unknown Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsv performed? Yes 2 X No 2 🗌 No 25. Was case referred to medical **Division of Vital** Be 26. Place of Death (Check only one) examiner? Hospital 2 X No ည 1 🗌 Yes Other: 1 X Inpatient 2 ER/Outpatient 3 E 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending I 1 X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined thin 24 hours a the Funeral D 1 🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 10 29d. Date signed (Month, Day, Year) Wellin 2011 Manles

Registrar

DHMH 17 Rev 7/2009

State

Nefliu MD 400 West 7th Street, Frederick, Maryland 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36634 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marilyn Faye Corridean October 27 2011 10:27P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Care, Howard Columbia Social Security Number 8. Date of Birth **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Days 216-68-1266 Hours April 29 Washington, D.C. ^a1955 56 **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo Maryland Howard Clarksville 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6805 Haviland Mill Road 21029 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black, White, etc. "natural", or 1 Never Married 2 Married þ 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: 3 Divorced Specify: Completed White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Comptroller Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Dwyer Elizabeth Hurd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lowell Corridean / Husband 6805 Haviland Mill Rd., Clarksville, MD 21029 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🗆 Burial 2 🛛 Cremation 3 🗀 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 10/28/11 Metropolitan Crem. Alexandria, VA 21. Signature of Furreral Service Licenses Name and Address of Facility
Muriel H. Barber Funeral Home 20882 Box 5038, <u>Laytonsville</u> 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final OVARIAN Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ate has been signed by the atte page 2 should be detached for Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy perform 1 Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spe 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending iniury work?
1 Yes 2 No Accident Investigation 3 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D64395 OCTOBER 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6336 CEDAR LANE COLUMBIA, MB 21044

DHMH 17 Rev 7/2009

Registrar

DOBERMAN, MD

Registrar's Signature

DANIEUE 31. Date filed (Month, Day, Year)

			1 - State of Maryland / Department	rtment of Health and Natificate of Death	, ,	ene g. No. 🤌 🙃	
			Registrar 1. Decedent's Name (First, Middle, Last)	intotto of Doda.	2. Date of Death	20	1 3. TIME 606 6135
Н	Physici		Alice Mae Collins		Month October	Day 20	Year 011 8:50 A M
1	/Medio		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of	
	LAdilli		Hospice of Queen Annes	Centreville		Oueer	n Anne
	Funeral		5. Social Security Number 6. Sex _ 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthplace (State or Foreign Country)
П	Director		217–28–4397 1□ M 2X F 79 Yrs.	Months Days Hours Min.	Dec 15 1	931	Maryland
	pu 🖈		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Loc	action			10d. Inside City Limits
	sho	5		Sation			1 □ Yes 2 No
	the M	Director	Maryland Caroline Marydel 10e. Street and Number	10f. Zip Code	10	g. Citizen of Wh	pat Country?
	with a or		19238 Crown Stone Road	21649		U.S.A.	
	eath	era			ecify Yes or No-		- American Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exercities Is and De natified at once.	by Funeral	1 □ Never Married 2 🖾 Married 1 □ Yes 2 🛣 No	Vas Decedent of Hispanic Origin? (Sp f Yes, specify Cuban, Mexican, Puerto □Yes 2 XNo Specify:	Rican, etc.)		White, etc. White
Ş.	hour tural			lent's Usual Occupation	1	6b. Kind of Bus	
15	in 72 n "na n edic	Completed	(Specify only highest grade completed) (Give	kind of work done during most of work OO NOT use retired)			,
212	with jiene r thai	E O	Elementary/Secondary (0-12) College (1-4or 5+) Time	keeper		manufa	ncturing
פ	othe othe	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M	aiden Surname)
<u>a</u>	uld be Aenta rked rlc ev	To B	Harry A. Burris	Pearl S.	. Seward		
ary	shou and N s mai	_	19a. Informant's Name/Relationship (Type. Print) 19b. Mailin	g Address (Street and Number or Rur	al Route Number,	City or Town, S	State, Zip Code)
Σ	and 2		Donald Lee Collins/ husband 19238	B Crown Stone Road	d; Maryde	1, MD 2	21649
ore	of He		20a. Method of Disposition 20b. Place of Disposition cemetery, cren	sition (Name of latery or other place)	Date 2	0c. Location - C	City or Town, State
Ĕ	Page nent int; II		1 M Burial 2 □ Cremation 3 □ Removal from State	lle Cemetery Oct	31 2011 7	[emplevi	ille, MD
Baltimore, Maryland 21215-0036	permit. Departr Importa any inju		21. Signature of Funeral Service Licensee 22	. Name and Address of Facility PO leegle and Helfent	Box 160;	Greens	sboro, MD 21639
	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause. Enter Underlying Cause (Disease or injury)		or respiratory arre		Approximate Interval Between Onset and Death
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P.O. Box	at the death certific by the attending p tached for use as	Physician/Me		Ectopic pregnancy Other (specify)		23d. Date Mon	of delivery th Day Year
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Division of Vital Records,	sician: The law r certificate has be irector, page 2 sh	Completed	Stenosis, hypertension		24a. Was an autopsy perform 1 □ Yes 2	/ pr jed? de	/ere autopsy findings available rior to completion of cause of eath? □ Yes 2 □ No
Ĭ	certif rector	Be	25. Was case referred to medical examiner?		h (Check only one		hs + 6 -
5	Phys	٦.	1 ☐ Yes 2 ☐ No ☐ Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of		ome 5 Reside		r (Specify) Nospice How
u O	ding I.h. After funer	tion	Natural 5 Pending (Month, Day, Year) Injury	Work? M 1 □ Yes 2 □ No	Zou. Describe no	w injury occurre	· ·
JINISI	al or Attendii s after death. al Director; A ed in by the fu	Certification: To	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, streamly building, etc. (Specify)		28f. Location (Str City or Town		r or Rural Route Number,
	To the Hospital or Attending Physician: within 42 hours after death: To the Funeral Director: After this certification ompletely filled in by the funeral director; to completely filled in by the funeral director; to the funeral director; the funeral director directors are directors.	edical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, deatt and manner stated.				
	Vithin vithin on the	Me	29b. Signature and title of certifier	29c. License number	29	d. Date signed	(Month, Day, Year)
	->-0		1	02020	c	mla	21.
,			30. Name and address of person who completed cause of death (Item 23a) (Type,	D 205173-	2	12	3/17
			Dr. Delboy; 6602 CHurch Hill Road;	,	1620		4
	Sta	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature				
P	Registra		MOVUL 2011 And A. Jak	f			

DHMH 17 Rev 1/2001

154

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36636 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 7, 2011 Physician/ Chipman Patricia 11:02A. M Kopf Medical a. Facility Name (if not institution, give street and number) 8515 60th Avenue City, Town, or Location of Death Berwyn Heights Ac. County of Death Prince George's Examiner 5. Social Security Number 218–34–3228 If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 💢 F Days Hours Apr. 1938 New York 73 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10d. Inside City Limits 10b. County death with the Maryland 10a. State 10c. City. Town or Location Director 1 Yes 2 No Prince George's Berwyn Heights Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20740 United States 8515 60th Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 filed within 72 hours after White If Yes, Give Year or Dates 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 XDivorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Leah Ferris Herman Kopf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Midvale Avenue Mt. Airy, Maryland 21771 Patricia D. Conte -daughter 20a. Method of Disposition
1 ☐ Burial 2 🖟 Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Metropolitan Crematory11/8/2011 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens Bornald Avers Borgwardt Funeral Home, PA Doneld 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 19 stilletes Acute Myocardial Infarction Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 1 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No been signed by the atte should be detached for Pregnant at time of death 5 Other (specify) 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? Yes 2 No 1 Yes 2 No certificate 25. Was case referred to medical director, 26. Place of Death (Check only one) Be examiner? Hospital 2 No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural iniurv 5 \square Pending 24 hours after death Funeral Director: A Accident Investigation completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number November 7, 2011 Derana luhal D26287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7305 Baltimore Avenue, #107 College Park, Maryland 20740

Registrar

DHMH 17 Rev 7/2009

NOV 1 6 2011

Michael Berard, 31. Date filed (Month, Day, Yea

M.D.

32. Registra's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 20 1 | 36637 State of Maryland / Department of Health and Mental Hygiene

		Registrar		Ce	ertifica	ite of	Death			Re	g. No.			
Physic ledical Exam			Ella Jo	ean Cha	lkle					Date of Deat Month November	b Day 7, 201			3. Time of Death 1659 hrs
		4a. Facility Name (if not institution 225 West High Street		Elkton Cecil										
Funera		5. Social Security Number	6. Sex	Months Days House Min										
Director		213-38-9738 Usual Residence of Decedent	1 M 2 X F	2XF 71 Yrs. Months Days Hours Min. 07/05/1940										
any		10a. State 10b. County		10c. City	, Town o	r Locatio	n	·					П	10d. Inside City Limits
Aaryland 28a-f show Lat once.	5	Maryland Ceci	.1	H	:1ktc	n								1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number	_											
ith the 23a o	E D	223 West High												
eath w	Funer	1 Never Married 2 X M	arried Armed F	orces?	J.S.	13. Was	Decedent of Hisp s, specify Cuban,	Mexican, Pu	? (Spec uerto Ri	cify Yes or No- can, etc.)	14	. Race - White,		can Indian, Black,
after d	by Fi	3 Widowed 4 Div	orced If Yes, Give Yes	2 X No		1 🗌 Y	res 2 X No	specify:			Sp	ecify:	Whi	te
hours natur Exami		15. Decedent's Education (Spec	cify only highest gra	Dates James grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use ordinal)										ndustry
036 thin 72 ne. • than "	Completed	Elementary/Secondary (0-12)	College (1	-4 or 5+)	1		uction			.,				al Motor
5-00 led with Hygien other	Son	17. Father's Name (First, Middle,	Last)			1100		8.Mother's N	lame (F	irst, Middle, M			icti	ıring
121(lbe fill ental F urked vent, g	B	Charles Robert		ck						estine				
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygine and England Beatment of Health and Mental Hygine Charles and Mental Hygine Charles if Health and Mental Hygine Charles in Health and No. 1 in marked other than "natural", or items 23a or 23a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	ြိ	19a. Informant's Name/Relations		1			Address (Street							
B, W and 2 Health litem 2		Dallas S. Chal 20a. Method of Disposition		20b.	Place of	Disposition	est High							Town, State
Baltimore, permit. Pages 1 an Department of Hea Important: If Iter		1 Bunal 2 X Cremation 4 Donation 5 Other Sp				y or othe	' '			mber 011				
altir rmit. 1 partm porta jury o		21. Signature of Funeral Service	Licensee	IX.	A. It	22. Nar	& Co., Inc	of Facility H	ick	s Home	for	Fune	era	ster, PA ls. P.A.
		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funer 103 W. Stockton Street, Elkton, I 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart											MD	21921
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.						ac or re	spiratory arre	st, shock,	or heart		Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Hypertensiv			Cardio	/ascular Dise	ase						Death
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8760, tificate be ng physici as the buri	n/Me	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, o	outcome of preg			death 3	Testopio por				ate of de		V
Box 68 e death certi the attendin ed for use a	icia	past 12 months?	4 Pregna	ant at time of de	2 L eath 5		death ⇒ · (Specify)	Tectobic bre	egnancy		Мо	inth	Da	ay Year
the dear y the a	Physicia	1 Yes 2 ✓ No 9 Unk	9 Unkno			- 45				Lie Billi				
Vital Records, P.O. Box 681 bysician: The law requires that the death certifi this certificate has been signed by the attending I director, page 2 should be detached for use as t	<u>ā</u>	Tall in Outo Significant Contains	one contributing to	dealir but not r	esulang l	n the und	erlying cause give	en in Part I.		1				ne cause of death?
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eco he law ate has	dmo								_	autopsy	ned?	dea	th?	mpletion of cause of
An: T	Be												2 No	
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Division of Vital Records, ral or Attending Physician: The law requires after death. al Director: After this certificate has been sided in by the funeral director, page 2 should be	Certification:	27. Manner of Death 1 Natural 5 Pendii	28a. Date of (Month,	of Injury Day,Year)	28b. Tin	ne of Injui		at Work?	28	d. Describe ho	w injury o	occurred		
Vision Atte	The state of the s											or Rura	al Route Number, City	
Dispital of the point of the po	Series	4 Homicide	Could not be determined (Specify) Could not be determined (Specify) Could not be determined (Specify)											
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier 1 Certifying Phyone) 2 Medical Exam	vsician: To the best niner:On the basis o	f examination a	ge, death nd/or inve	occurred estigation	at the time, date , in my opinion, d	and place, a	and due	to the cause(time, date ar	(s) and mand place,	anner as and due	stated to the	i. cause(s)
To wit	Me	29b. Signature and title of certifier	and manner stated.											
2.		Theodore W	u.K.	JA.	ast.	7	O.C.M.	E. 0	CME		Novem	ber 8,	2011	
18	İ		ddress of person who completed cause of death (flem 23a) M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223											
91	ate	Theodore M. King, Jr., 31. Date filed (Month, Day, Year)					U VV. Baltimo	re Street,	Balti	more, MD	21223			
Regist		NOV 1 6 2011	Beneva	B. 1	O ENE	evel.								

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar 36639 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ bckober 8:03 P M 29, 2011 Ruperta S. Dominguez Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 14400 Brad Drive Rockville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Rinth g. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Min Hours 219-82-8077 Director 1 M 2 XF 78 May 12, 1933 Philippines Usual Residence of Dece 28a-f show 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland Director Yes 2 No MD Montgomery Rockville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 14400 Brad Drive 20850 itеms 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Medical Examiner Black White etc or þ 1 Never Married 2 Married Specify Pacific Islander Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Teacher Education of Health and Mental Hyginitem 27 is marked other other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Leandro Songuiam Maria Supangan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a Agnes D. Mars/Daughter 17721 Chipping Court, Olney, MD 20832 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or conce. 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Nov. 2011 Rockville, MD 4 ☐ Donation 5 ☐ Other (Specify) Parklawn Memorial Park Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, 21. Signature of Funeral Service Licensee MD 20901 23a. Part 1. Enter the disease, or complications that caused be death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Sudden Cardiac Death disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Diabetes Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Hypertension Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hyperlipidemia Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death signed by the at Id be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 A No 3 ☐ Probably 4 ☐ Unknown Completed phods 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2x No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🗌 No 1 X Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur and the of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Ravi Passi, MD

NOV 0 1 2011

31. Date filed (Month, Day, Year

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

D28656

15245 Shady Grove Road, #130, Rockville, MD 20850

October 31, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 20 | | 36640 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ $P^{\ M}$ D'Amato October 2011 6:30 Mary Jean Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Frederick Ijamsville 3312 Nicholas Court 8. Date of Birth (Month, Day, Dec. 8, g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs Social Security Number Age (In vrs. last birthday) **Funeral** Country) Maryland Hours 1 🗆 M 2 🕱 F Months 1955 Dec. 217-70-5847 55 **Director** Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State notified at Director 1 Yes 2 X No 28a-f Ijamsville Frederick Maryland 2 should be filed within 72 hours
Ith and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28
27 is marked other than "natural", or items 25a or 28 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21754 3312 Nicholas Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black White etc. ☐ Yes 2 🗷 No ģ 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 K No Specify. Specify. If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry Decedent's Education (Specify only highest grade completed) during most of working College (1-4 or 5+) Elementary/Seconday (0-12) U.S. Government Systems Analyst Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evidence. ည Ruth Wonning William Hoerst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3312 Nicholas Court Ijamsville, Maryland 21754 Tony D'Amato / Husband Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 24 1 Burial 2 X Cremation 3 Removal from State October 4 ☐ Donation 5 ☐ Other (Specify) Frederick Crematory 2011 Frederick, Maryland 21. Signature of Juneral Service Licensee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Frederick, Maryland 21702 1621 Opossumtown Pike when 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final OF THE LUNG ADENSOFFICINOMA Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to for as a consequence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I autopsy performed: 1 🗌 Yes 2 🔲 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 10 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 1 Anatural work? 1 ☐ Yes 2 ☐ No injury 5 Pending Investigation Accident filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the F only one 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certifig 03176 30. Name and address of person who completed cause of death (Item 23a) (Type, Print

DHMH 17 Rev 7/2009

10

State Registrar

O'CONNOR

MA

Registrar's Signatu

501 W SEVENOTH ST.

FRE BERICK

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3664 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 70/58/5071 Shirley Darby 05:44 AM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Southern Maryland Hospital Clinton Prince Georges Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 577-58-1690 70 **Director** 1 □ M 2 🔀 F 01/28/1941 SC 28a-f show 10a. State the Maryland 10c. City, Town or Location Examiner must be notified at Director 10d. Inside City Limits MD Charles Waldorf 1 Yes 2 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 1915 Michael Rd. 50707 AZU permit. Page 1 and 2 should be filed within 72 hours after death \text{Oppartment of Health and Mental Hygiene.} Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner muone. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Midowed 4 Divorced Specify: Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 3 Security Specialist Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 Leonard Smith Evelyn P. Femster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles Darby / son 8006 Wannis Ct., Clinton, MD 20735 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Washington NationalCem 11/7/2011 Suitland, MD 21. Signature of Funeral S 22. Name and Address of Facility Strickland Funeral Services 6500 Allentown Rd., Camp Springs, MD 20748 23a. Palt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ o Cindin disease or condition Medical resulting in death) Due to (or wa a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) signed by the attending physician and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical • Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
• Funeral Director: After this certificate has been signed by the attending physicii Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ≥ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 □ No 3 □ Probably 4 □ Unknown s certificate has been sidirector, page 2 should it 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 1 🗌 Yes 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 IDOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check 2 Hedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 1012311

DHMH 17 Rev 06-2011

State Registrar

10

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

20+1

3001 Hospital Drive, Cheverly, Maryland 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36643 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Edward Allen Fidel October 29, 201^{Year} 7:20 P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Manor Care-Chevy Chase Chevy Chase Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Hours 577-60-7325 1 M 2 □ F **Director** 96 Nov. 17, 1914 CO Usual Residence of Dec show the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 28a-f 1 Yes 2 X No MDMontgomery Chevy Chase 0 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a with 8700 Jones Mill Road 20815 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Armed Forces?
1 ☐ Yes 2 ☐ No o by Black White, etc. Page 1 and 2 should be filed within 72 hours after or ment of Health and Mental Hygiene. :ant: If item 27 is marked other than "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify. If Yes, Give th and Mental Hygiene. 27 is marked other than "natural", traumatic event, the Medical Exa 3 Midowed 4 ☐ Divorced Completed Year or Dates Decedent's Education Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5+ Foreign Service Officer US Dept. of State Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Anthony George Fidel Anne Bagley Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen Chapman/Step-son 5257 Nebraska Avenue, NW, Washington, DC 20015 other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o cemetery, crematory or other place) Oct. 1 Burial 2 Cremation 3 Removal from State 31, 4 Donation 5 Other (Specify) Alexandria, VA Metropolitan Crematory 2011 21. Signature of Funeral Service Lice e Francis Agress Corinns Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Pneumonia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last attending physiciar Physician/Medical certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown P.0. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an has autopsy performed? certificate the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 욘 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral dir 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of After 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury s after death.

I Director: After force of the force of t 1 ☐ Yes 2 ☐ No М ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) of 24 hours. the Funeral Directory and filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 2 D54566 10 Oct. 31, 2011

State

Registrar

9801 Georgia Avenue, Silver Spring, MD 20902

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Sign

Sunitha Bhogavilli, MD

NOV 0 1 2011

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle Last) 2. Date of Death Physician/ tuchigami 1615 PM Ann & U OCTOBER 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death Battimore The John Hopk CITY Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months 213 58 5300 **Director** 1 M 2 XF 63 1948 May 24, Washington DC 28a-f show with the Maryland 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 🗆 Yes 2 🔀 No MD Howard Ellicott City 10e. Street and Number ms 23a or must be r ò 10f. Zip Code 10g. Citizen of What Country? 7839 Rockburn Drive 21043 United States items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. 9 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Specify: White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ဂ္ဂ Edward Lee Goodwyn Elizabeth Howe permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic or 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Harry Fuchigami/Husband 7839 Rockburn Drive Ellicott City, MD 21043 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Ardent Crematory 4 ☐ Donation 5 ☐ Other (Specify) 11-1-2011 Hanover, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilit Harry H. Witzke's Family FH Inc. Gllnis 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Pregnant at time of death
Unknown been signed by the s should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🗚 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: ည Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) funeral 28a. Date of injury (Month, Day, Year) Z. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 5 Pending work n 24 hours after death.

e Funeral Director: Ai bletely filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the F 3 [only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature OCTOBER 31, 2011

State Registrar

0

Wolfe Street Bultimore, MD 21208

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 2 201

Bobby Burches, Ir

600 North

Registrar's Signature

			State of Maryland / Dep		Mental Hygie	ene g. No. 2011 36645
	Physicia	n/	State Registrar Amend#5. PerInfrmnt. PGC11-9-198 1. Decedent's Name (First, Middle, Last)	amcate of Death	2. Date of Death	3. Time of Death
	Medic	al	Nancy Ellen Fenstermaker 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		31, 2011 11:27 AM
	Examin	er	5600 43rd Avenue	Hyattsville		Prince George's
T	Funeral		5. Social Security Number 6. Sex 7. Age (<i>In yrs. last birthday</i>) 577— 16 —5585 1 □ M 2 ☒ F 75 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y. March 5,	9. Birthplace (State or Foreign Country) 1936 Bladensburg, MD
	Director		577-16-5585 1 M 2 M F 75 Yrs. Usual Residence of Decedent		March 5,	1936 Bladensburg, MD
	yland -f shov ed at	ctor	10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
	nr 28a- notifi	Director	Maryland Prince George's Hyatts	VIIIe 10f. Zip Code	10	1 ☑ Yes 2 ☐ No
	with the 23a cast be	Funeral	5600 43rd Avenue	20781	10	USA
	death items		11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
036	s after al", or Exami	d by	1 □ Never Married 2 ☑ Married 1 □ Yes 2 🔣 No	1 ☐ Yes 2 🖾 No Specify:		Specify: White
2-0	2 hours "natur	Completed	15. Decedent's Education 16a. Dece	dent's Usual Occupation kind of work done during most of work	kina 1	6b. Kind of Business Industry
121	ithin 7; ene. • than	Com	Elementary/Seconday (0-12) College (1-4 or 5+) life. D	nemaker		Own Home
2 ام	illed wall Hygin	Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma	uiden Surname)
ylar	lid be i Menta narked	인	Edward Foy Johnson		. McMillia	
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	100	19a. Informant's Name/Relationship (Type, Print) 19b. Maili Frederick A. Fenstermaker / Husband 5600	ng Address (Street and Number or Rui 43rd Avenue, Hyat		
re,	1 and of Heal item;		20a. Method of Disposition 20b. Place of Dispo			0c. Location - City or Town, State
ij	Page ment tant: If jury or			tan Crematory 11/1	· .	lexandria, Virginia
Bal	permit Depar Impor any in	10		2. Name and Address of Facility asch's Funeral Hot	me, P.A.	4739 Baltimore Avenue Hyattsville, MD 20781
П			23a. Part 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest	Interval Between
parties .	Physician/ Medical	i	resulting in death)	war insuff	chency	Onset and Death
	Examiner		Due to (or as a consequence of):			
7	d sit	Examiner	Sequentially list conditions, b. Due to lor as a consequence of cause. Enter Underlying			
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Box 687	eath certifica attending p	Physician/Me	in the past 12 months? 1 Live Birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
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Sec	The law cate has page 2	Completed			autopsy perform 1 \(\sum \) Yes 2	prior to completion of cause of death?
tal	nysician: The nis certificate I director, pag	Be C	25. Was case referred to medical examiner?	26. Place of Death (Che		Anol 12 100 Parts
Ž	Physic this or	<u>ان</u>	1		lome 5 Resider	nce 6 Other (Specify)
ouc	Attending Pher death. ector: After the by the funeral	icate	1 🛣 Natural 5 □ Pending (Month, Day, Year) injury 2 □ Accident □ Investigation	work? M 1 ☐ Yes 2 ☐ No	20d. Describe nov	Vinjury decarred
Division of Vital Records,	I or Attending after death. Director: After I in by the fune	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physompleted filled in by the funeral director, page 2 should be detached for use as to complete the funeral director.	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or investigation).	stigation, in my opinion, death occurred	at the time, date and	place, and due to the cause(s) and manner stated.
	To the within.	Ž	only one) 3 L Certifying Nurse Practioner: To the best of my knowledge, 29b. Signature and title of certifier	death occurred at the time, date and pla 29c. License number		ause(s) and manner as stated. Od. Date signed (Month, Day, Year)
			Mand D. Weltzen	D23743		11/1/2011
2	5		30. Name and address of person who completed cause of death (item 23a) (Type, Martin D. Weltz, M.D., 7525 Greenway		205, Gree	nbelt, MD 20770
ľ	Stat Registra		31. Date filed (Month, Day, Year) NOV 0 3 2011 32. Registrar's Signiture			

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		_ For	Pleas	se Type or State o			ndelible Ink artment of H		-	iene		C C C
		State Registrar 1. Decedent's Name	o /First & distable	I cot)	_	Cer	tificate of E	Death	T	eg. No. 20		6646
Physicia Medic	al	Alice 4a. Facility Name (if		Elaine		Ferris	T		2. Date of Deat Month	3 A	011 20	e of Death
Examin	er	WMHS		give st re et and numi	per)		4b. City, Town, or Cumbe	Location of Death erland		4c. County of Alleg		
Funeral Director		5. Social Security No. 579-52-		5. Sex 1 M 2 F	7. Age (In yrs. Ia	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day Apr 21	Year) 942	9. Birthplace (Sta	te or Foreign
	L	Usual Residence of 10a, State				. Town out o			Aprizi	, 1042		
Marylan 28a-f sh notified a	Funeral Director	MD	Alle	egany	Toe. City	y, Town or Lo Cur	mberland					e City Limits Yes 2 🗆 No
with the 23a or 1st be r	eral	10e. Street and Nun	^{nber} arroll Str	eet			10f. Zip Code	21502	1	0g. Citizen of Wh	at Country?	
death r items iner mu		11. Marital Status		12. Was Deced	dent Ever in U.S	S. 13. \	Vas Decedent of Hi f Yes, specify Cuba		ecify Yes or No- Rican, etc.)	14. Race -	American Indian),
rs after ural", o LExami	ed by	1 ☐ Never Marri 3 ☐ Widowed		ed 1 Yes If Yes, Give Year or Da			☐ Yes 2 No	Specify:		Specify:	white	
72 hou n "natu Aedica	Completed			's Education t grade completed)		(Give	lent's Usual Occupa kind of work done d O NOT use retired)		king	16b. Kind of Bus	iness Industry	
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d 2 should alth and M 27 is ma r trauma		19a. Informant's Na Tammy	me/Relationship Martellini		daughte	19b. Mailir 34	ng Address (Street a 05 Sliding	nd Number or Rur Rock Dr	al Route Number, IVE MCK	City or Town, Sta	te, Zip Code)	75070
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.				B Removal from	State Sc	lace of Dispo emetery, cren arpelli F	sition (Name of natory or other place uneral Hom	e. P.A.	Date 11-4-201	20c. Location - C	ity or Town, State	MD
permit. P Departm Importar any injur		21 Signature of Fur				.	. Name and Addres	: ฮิเกิ Fันที่ĕral ⊢			_	
		23a. Part 1. ter ti shock. hear	he disease, or contract failure. List on	omplications that cally one cause on each	aused the death	n. Do not ente		rginia Avenu g, such as cardiac			Approxi	mate Between
Physician/ Medical		Immediate Cause (disease or conditio resulting in death)	Final	_ a	buna	M]	nact	Infect	00			nd Death
Examiner				Due to (c	or as a consequ	nercotof):	at for	lune			Do	Voc.
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be executed sician and burial-transit	Exa	that initiated events resulting in death) I	3	c. Due to (c	or as a consequ	ience of):						
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the death by the att	Physician/Medi	in the past 12 r 1 Yes 2 9 Unknown	No		ant at time of c		Other (specify)	у		Mont	h Day	Year
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nysicia nis certi directo	To Be	examiner?	No	Hospital:	npatient 2 🗆	ER/Outpatier	Otho	er: 4 Nursing H	ome 5 🗆 Reside	nce 6 🗆 Other	(Specify)	
ending Phath.	Certificate:	27. Manner of Death 1 Natural 2 Accident	5 Pending Investiga	tion	f injury n, Day, Year)	28b. Time of injury	work		28d. Describe ho	w injury occurred		
al or Atte s after de il Directo ed in by th		3 ☐ Suicide 4 ☐ Homicide	6 □ Could no determin	ed 28e. Place	of Injury - At ho g, etc. (Specify,		eet, factory, office		28f. Location (Sta City or Town		or Rural Route N	umber,
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompleted filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2	Medical Example 1	Physician: To the be aminer: On the basis	s of examination	n and/or invest	ilgation, in my opinio	n, death occurred a	at the time, date an	d place, and due t	o the cause(s) and	d manner stated.
To the complete of the complet		29b. Signature and t	title of certifier	MIG	MD		29c. License			9d. Date signed ()
12		30 Name and addre	ess of person wh	no completed cause	of death (Item	23a) (Type, F			A Con and	001004	MD-	21502
Stat Registra		31. Date filed (Month		32. Re	gistrar's Signat	webark	rint)	000	· COM	INCONCO NON		
. region a		1101	1 0 401	· Marin	/ /							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36647 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October Physician/ 29.2011 6:16pm Marla Fran Gilson Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner Chevy Chase Montgomery 2805 Washington Avenue If Under 1 Year Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** (Month, Day, Year) Director 101-42-6301 1 M 2 X F Yrs 08/23/1951 New York 60 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location Director Examiner must be notified 1 Yes 2 X No Chevy Chase Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a 20815 u.s.A. 2805 Washington Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? or 1 Never Married 2 X Married þ 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Public Affairs Consultant/Lobbyist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental I is marked o ည Selma Robbins Rabinowitz Bernard Gilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ge 1 and 2 sl it of Health a If item 27 is 2805 Washington Avenue, Chevy Chase, MD 20815 Carl Tuvin - Spouse 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Department c Important: If any injury or ò Beth Thiloh Cem. 10/31/2011 | Woodlawn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. ture of Funeral Se M00709 11800 New Hampshire Ave., Silver Spring, MD 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart value. List only one cause on each line. Approximate Interval Between Onset and Death
10 Months Immediate Cause (Final Ph sician/ Acute Myeloid Leukemia disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Month Dav Pregnant at time of death ed by the a 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 X No 3 Probably 4 Unknown Completed been Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has page 2 death?
1 Yes 2 No After this certificate Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) 1 Yes 2 X No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number,

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: I Director: A hours after death filled in by within 24 hours a To the Funeral L

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9233 Singleton Drive, Bethesda, Maryland 20815 Williams 00. Cynthia M.

2. Registrar's Signature

determined

State Registrar

Medical

4 Homicide

29a. Certifier

(Check only one 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

H0058032

29d. Date signed (Month, Day, Year)

October 30, 2011

29c. License number

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lanuel Enrique l	Dia.	1- For State	e of Marylan	•	tment of		d Mental	, 0	2	กเ	1 3551
Physicia		Registrar 1. Decedent's Name (First, Middle,Lo						2. Date of De Month		<u>U I</u>	3. Time of Death
Medical Examir	ner	Manuel Enrique						Novembe	er 6, 2011	ear	1634 hrs
		4a. Facility Name (if not institution, g Race Road and Park Cir-		er)	1	lb. City, Town, or Hanover	Location of D	eath	4c. Count		
Funeral		Social Security Number 6.	Sex 7.	Age (In yrs. las	t birthday)	If Under 1 Yea	ar If Under 24	Hrs. 8. Date of B	irth(MM/DD/YY)	(Y) 9. Bin	the ace (State or an
Director		733-14-1667	X.MM 2F	37	Yrs	Months Day	s Hours	Min. July 1	5, 1974	Foreig Co	untryRepublic
A		Usual Residence of Decedent 10a. State 10b, County		Idon City T	own or Locati						
and show any		MD Montgo	nm <i>er</i> tv		lver S						10d. Inside City Limits 1 Yes 2 X No
arylan 8a-f si	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of V	Vhat Cour	
th the Maryland 23a or 28a-f sho notified at once.		9625 Mount Pisg	gah Road			20903			USA		
th with	uneral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decede		13. Wa	s Decedent of His es, specify Cubar	spanic Origin?	(Specify Yes or N		ce - Ameri	can Indian, Black,
er dear	ᄔ		1 Yes	2 X No		Yes 2 No				Whit	e
ours aft Itural' Amino	e e	15. Decedent's Education (Specify	or Dates:	ompleted) 1	6a. Decedent	's Usual Occupa	tion (Give kind	of work done	16b. Kind of E		
6 172 bo	Completed	Elementary/Secondary (0-12)	College (1-4 c	or 5+)	during mo	ost of working life	. DO NOT use	retired)			
5-0036 led within 72 Hygiene. other than '	E	17. Father's Name (First, Middle, Las		4	Busin	ess Admi				ounti	ng
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	BeC	Ramon Emilio Dia	•	2				ame (First, Middle, a Gomez	Maiden Surnam	e)	
MD 21215-003(d 2 should be filed within th and Mental Hygiene. n 27 is marked other the numatic event, the Media	2	19a. Informant's Name/Relationship ((Type, Print)				et and Number	or Rural Route Nu			
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. ten 27 is marked other than "natural", or items 23s or 28s-f she traumatic event, the Medical Examiner must be notified at once	1	Fredy Linares de 20a. Method of Disposition	la Cruz/I						_		
Baltimore, MC permit. Pages 1 and 2 s Department of Health a: Important: If iten 27	- 1	1 Burial 2 Cremation 3	X Removal from	State cre	matory or oth		N	ov. 15,		eta d	e Yasica,
it. Pagirtment	-	4 Donation 5 Other Specification 21. Signature of Funeral Service Lice		Saba		e Yasica		2011			a, Dominican
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Physician		23a. Part I. Enter the disease, or comfailure. List only one cause on e	plications the cause	ed the death. D	o not enter th	e mode of dying,	such as cardia	ac or respiratory ar	rest, shock, or h	eart	Approximate Interval Between Onset and
/Medical Examiner	Ì	Immediate Cause (Final disease a	Hanging							1	Death
	-	or condition resulting in death)	Due to (or as a cor	sequence of):							
	힐	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a con	sequence of):							
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Box 6876C death certificate the attending physed for use as the broad and the broad are the broad ar		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outo	ome of pregnar	. —	al death 3	Ectopic pre	gnancy	23d, Date of Month	_	ay Year
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the de by the ched for	ᇍ	Part II. Other significant conditions	a Cukupwu	ath but not resu	Ilting in the ur	iderlying cause o	iven in Part I	23e Did t	obacco use cont	tribute to 1	he cause of death?
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of Vital Recing Physician: The After this certificate The Thereral director, page	인	1 ✓ Yes 2 No			R/Outpatient			rsing Home 5			Scene
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r Atter er deal rector	ള	2 Accident Investigat	28e Place of			, factory, office b		28f. Location (Street and Numb	per or Rur	al Route Number City
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	ĕ⊦	29b. Signature and title of certifier	and manner stated	i.		29c. License			29d. Date sign		
1-PEND		Carol	Hall	2acr		O.C.N	И.E.		November	· 7, 201	1
		 Name and address of person who Carol Allan, MD Assista 	completed cause of ant Medical Exa			more Street,	Baltimore,	MD 21223			
Sta	600	31. Date filed (Mouth, Day, Year)	32. Registr	ar's Signature	park	1	<u> </u>				
Registra	ar_ .4	107 1 0 201	OCME	UB.	grave		_				

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riease	I voe or Print in	Black indelible ink.	Ensure All Col	oles are Legible

orothy Hazel Goldmeier State of Maryland / Department of Health and Mental Hygiene 1-For State Certificate of Death Reg. No. 2011 3664												
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Physici edical Exami		Decedent's Name (First, Midd	Dorothy	Hazol G	aldmoios	1			Month November	Day Year		3. Time of Death 1438 hrs
		4a. Facility Name (if not institution				b. City, Town,	or Location o			4c. County of	Death	
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Funeral Director		5. Social Security Number	6. Sex		2	If Under 1 Y	ays Hours			9/1937	Foreign	
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r any		10a. State 10b. County		10c. City	, Town or Locatio	n						10d. Inside City Limits
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with th us 23a ne noti		11. Marital Status	perus Dr 12. Was De	codent Ever in U	.S. 13. Was	Decedent of I			cify Yes or No-			ean Indian, Black,
death or iteu	Funeral	1 Never Married 2 M	arried Armed F	orces?	If Ye	s, specify Cub	an, Mexican,	Puerto R	ican, etc.)	White,		,
s after ural",	à	3 X Widowed 4 Div	orced If Yes, Give Ye or Dates:		1 16a. Decedent	Yes 2 X N		ind of wo	rl, dono	Specify: 16b. Kind of Bus		Caucasian
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Com Med Co	O B	19a. Informant's Name/Relations		neu	19b. Mailing	Address (Str	eet and Num	ber or Ru		ber, City or Town		Zip Code)
MD 21 d 2 should Ith and Me n 27 is ma	.]	Karen Goldmeier	Green/Do									land 20815
or Health of Her traum		20a. Method of Disposition 1 X Burial 2 Cremation	3 Removal f		Place of Disposit crematory or other		cemetery,		Date	20c. Location -	City or T	Fown, State
Baltimore, permit. Pages I a Department of He Important: If ite		4 Donation 5 Other Sp 21. Signature of Funeral Service		Co	lumbia M	em. Pa	rk	11/0	9/2011	Clarks	vill	Ce, MD
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Physician		23a. Fart I. Enter the disease, or failure. List only one cause		caused the death								Approximate Interval Between Onset and
`∖/Medical ≞xaminer		Immediate Cause (Final disease or condition resulting in death)	a Verapa		<u>oxicatio</u>	n						Death
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SOX leath or attender for use	/sici	1 Yes 2 No 9 Uni	Known 9 Unkr	nant at time of de nown	eath 5 Oth	er (Specify)			-			
O. B at the da d by the		Part II. Other significant condit	ions contributing	to death but not r	esulting in the ur	derlying caus	e given in Pa	rt I.	23e. Did to	bacco use contrib	ute to t	he cause of death?
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Division pital or Attendio ours after death. teral Director: A	Certification:	3 X Suicide 6 Coul	d not be		ome, farm, street		building, etc	- 1	or Town, S	tate) 54 1 3	r or Rur l esp	al Route Number, City erus Dr.
Tospita 4 hours funera		4 Homicide 29a. Certifier	hysician: To the be		d:Reside		date and pla		ue to the caus		as state	ed.
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the b	Medical	(oncon only	miner:On the basis and manner	of examination a			-					
H×H3	Ě	29b. Signature and title of certifie					nse number			29d. Date signe		
		() (and est	ell)			0.0	C.M.E.			November	, 201 	1
		39. Name and address of person Laron Locke MD. A	who completed cau ssistant Medic	•	•	timore Stre	et, Baltim	ore, M	D 21223			
	·u.c	31. Date filed (Month, Day, Year)		egistrar's Signat	park.	,						<u>.</u>
Regis	ırar	MUY I U Z	011 Den	un po.	14							

36650

Year

29d. Date signed (Month, Day, Year)

10/28/2011

State Registrar

29b. Signature and title of certifier

ANDREW

ESC THOMAS VOHINON DR, FREDERICE DONELSON MO Registrar's Signatur

onelson

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c, License number

121936

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36651 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October Cecilia Edna Cooper Grace 2011 9:25 p M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death 134 Louisa Lane Charlestown Cecil Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept. 28,1928 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 X F Days Min. 219-22-5677 Country) Maryland 83 **Director** Usual Residence of Decedent 10a, State 10b. County be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho 10c. City, Town or Location 10d. Inside City Limits Director Maryland 1 X Yes 2 No Cecil Charlestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 134 Louisa Lane 21914 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. δ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 🔀 No Specify: Completed 3 Widowed 4 Divorced White Year or Dates and Mental Hygiene.
I is marked other than "natur raumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Charlestown Elementary School Elementary/Seconday (0-12) College (1-4 or 5+)
Two Years Secretary C<u>harlestown</u>, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ano...
of Health an...
Witem 27 is mark...
'Ar traumatic er ပ Cecil Clifford Cooper Edna Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudia G. Patterson (daughter) 1489 Clayton Street, Perryville, Maryland 21903 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charlestown Cemetery 11/01/11 Charlestown, Maryland 22. Name and Address of Facility Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ AWTE MYELOGENOUS LEUKIENIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant 9 Unknown Pregnant at time of death 5 ☐ Other (specify) Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy performed? Yes 2 ☑ No death? To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 \square Nursing Home 5 \nearrow Residence 6 \square Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 1 Kertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title 29d. Date signed (Month, Day, Year) D0062190 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

SHAHNAWAZ KITAN 31. Date filed (Month, Day, Year)

Maryland 21215-0036

Baltimore,

Box 68760

Records,

Division of Vital

2533 AUGUSTINE HERMAN HWY, SUITEA, CHESAPEAKE CITY, MD 21915.

32. Registrar's Signature

		State Registrar			<u> </u>	Tilicate	of Dea	airi		F	Reg. No.		1_36	LU.
Physicia	n/	1. Decedent's Name (First, Middle	,							2. Date of Dea		Year	3. Time of I	
Medic	al	Peggy Joyce Gr								October			1:10	P
Examin	er	4a. Facility Name (if not institution Chesapeake Woo	-			4b. City, To	wn, or Loc bride		Death			y of Death Cheste	er	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1	Year If	f Under 24	4 Hrs.	8. Date of Birth	1	9. Birtho	place (State or	Forei
Director		214-34-7706	1 □ M 2 🛣 F	75		Months	Days H	Hours	Min.	October Day	24°, 1936	Coun	^{tr} Maryla	ınd
d d	_	Usual Residence of Decedent 10a, State 10b, County		100 City	, Town or Lo	cation						14	10d. Inside City	Limit
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Director			Too. Oily	Dent							ľ	1 □XYes	
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DHMH 17 Rev 7/2009

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	DI		1. Decedent's Name (First, Middle, Last)						2.	Date of Deatl		Year	3. Time of Death
	Physici: /Medic		Maxwell Gree	son					0	ctober	22	2011	09:20 P M
100	Examin	er	4a. Facility Name (If not institution, give s		r)		4b. City, Town, c				1 _	unty of Death	
and the second			Hospice of Queen A 5. Social Security Number 6. Sex		Age (In yrs. la	ast hirthday)	Cent:	revil.		Date of Birth		ieen Ar	place (State or Foreign
	Funeral Director			M 2□F	75	Yrs.	Months Days	Hours	Min.	(Month, Day,	936	Cou	bot, MD
			Usual Residence of Decedent						1 1				
	arylar show	_	10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits 1 X Yes 2 □ No
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9	after o	표	1 XNever Married 2 Married	Armed Forces 1 ☐ Yes 2 ☐	3?		Was Decedent of I			cán, etc.)		Black, White	
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ary	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, The Modical Exprairment as the notified at		19a. Informant's Name/Relationship (Type	pe. Print)		19b. Maili	ng Address (Street	and Numb	er or Rural F	Route Number	, City or T	own, State, Z	ip Code)
Σ.	and 2 ealth m 27		Elvernace Vonville	e/ compa	nion	10 W	. First	Street					
ō E	ges 1 If itel or otl		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ R	emoval from Stat			sition (Name of matory or other cia		Dat			tion - City or T	
altimore, Maryland 21215-0036	it. Par rtmen rtant: njury		4 ☐ Donation 5 ☐ Other (Specify)		Che		ke Cremat						
Ba	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service License	e		- 1	2. Name and Addre leegle a				-		oro, MD 2163
	_		23a. Part 1. Enter the disease, or compli-	cations that caus	ed the death	-						nome,	Approximate
V	Physician	Ø. 1	shock, or heart failure. List only on Immediate Cause (Final	e cause on each	line.	-11.0	- esop	100					Interval Between Onset and Death
-	/Medical		disease or condition resulting in death)	Due to (or a	as a cons a	ence of):	- 2300	7	,,-			-	1 U cal
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	ed sit	Examiner	Sequentially list conditions, if any loading to immediate cause. Enter Underlying	Due to (or a	as a conse u	ence of							
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989	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	edic											
Box	eath certific attending p for use as	Physician/Me	23b. was decedent pregnant	3c. If yes, outcon 1 ☐ Live birth			☐ Ectopic pregnan	Ov			23	d. Date of del	
m C	ed for	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnan	t at time of de		Other (specify)					Month	Day Year
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Records,	has has ge 2 s	Completed								24a. Was a autops perfori	sy .	24b. Were au prior to death?	topsy findings available completion of cause of
			25. Was case referred to medical							1 □ Yes	2 No		2 □ No
5	/slcla s cert directo	o Be	examiner?	lospital:	atient 2 🗆	ER/Outpatie	nt 3 DOA Ot	nor:		Check only on 5 ☐ Reside	-	Other 1886	mu & Que
<u> </u>	g Phys ter this neral dir	n:T	27. Manner of Death	28a. Date of I		28b. Time o		iry at		d. Describe h			T" Auw
Ö	endin ath. or: Af	atio	1 Natural 5 Pending investigation	(Wonar,	Day, rear)	injuity		Yes 2]No				- 10
Division of	al or Attending Pi s after death. al Director; After ti ed in by the funeral	Certification: To	3 Suicide 6 Could not be determined	28e. Place of building,	injury - At ho etc. (Specify	me, farm, st	reet, factory, office		28	f. Location (S City or Tow	treet and n, State)	Number or Ru	ıral Route Number,
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	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director,	edical	29a. Certifier Certifying Physical Check only one)	ner: On the basis	s of examinal	tion and/or in	th occurred at the nivestigation, in my	opinion, de	eath occurred	d at the time, o	date and p	lace, and due	to the cause(s)
	omple	Med	29b. Signature and little of certifier	und manner			29c. Licen	se number		2	29d. Date	signed (Mont	h, Day, Year)
	->-0		1				1000	538	15		12	1/2/	11
			30 Name and address of person who co	mpleted cause o	f death (Item	23a) (Type,	29c. Licen D 60		2)	,		11.	
			KORAH PULL	MODD	9/2/) Ma	rket.	se ,	ven	ton	MD	0/60	79
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ORIGINAL

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2011 36654 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) November 1, **Physician** 2011 **JOSEPHINE** Α. GRIFFITH 5:45 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Snow Hill Nursing & Rehab.
5. Social Security Number 6. Sex 7. Snow Hill

If Under 1 Year If Under 24 Hrs.

Months Days Hours Min.

8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗙 F Months 227-07-2227 Yrs 92 June 21, 1919 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County rthan "natural", or itema 23s or 28s-f show Its Medical Examinar must be notified at 1 ☐Yes 2 ☐ No Director Maryland Crisfield Somerset 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 18 Columbia Avenue 21817 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 end 2 should be filed v Department of Health and Mental Hygie Important: If itsm 27 is marked other til any injury or other traumatic event. Ills 2008. 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 John William Stoy Hannah Kershaw 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mona J. Griffith (Daughter-In-Law) 3835 Walt Thomas Road - Crisfield, MD 21817 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 11/2/2011 Delmar, Delaware 21. Signature of Funeral Service Libensee

Mary Beth Bradshaw-Pruitt 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Athero Sclerosis **Physician** oronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner Hospitel or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Year Month Day 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown sate has been signed I page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 2 No After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manger of Death 28d. Describe how injury occurred 28b. Time of Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours aftar deati To the Funeral Director: completely filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Sign live d title of certifier SARAD R. BARAL, MI) Name and address of person who completed cause of death (Item 23a) (Type, Print), 604-Market St.; (Octomoble) MD 2/85/ 604-Market 31. Date filed (Month, Day, Year) Registrar

			for State	State of Mary	/land / [1ental Hyg	giene		
			Registrar 1. Decedent's Name (First, Middle, Last)			Certifica	te of Deat	in	2. Date of Dea	Reg. No.	111	36655
	Physicia		T 1/	' m	1400	-: 6			Month / O	Day	Year 2 0 / /	3.48 A M
	Medic Examin		4a. Facility Name (if not institution, give of	eet and number)	1141	4b. Cit	y, Town, or Locat	tion of Death	70	4c. Coun	ty of Death	3.7011
				ice Hou.	SE.	Ē	GSTON			TA	Albot	-
	Funeral Director		5. Social Security Number 6. ¶ex 1	7. Age (In	yrs. last birtl	nday) If Und Months		nder 24 Hrs. urs Min.	8. Date of Birth (Month, Day	(Year)	Coun	
			Usual Residence of Decedent		17	113.			09-02-	1932	Mac	yland
	/land f shoved ad at	tor	10a. State 10b. County	10	c. City, Town	or Location					1	0d. Inside City Limits
	e Mar 28a- notifie	Sire	Md. Queen 1	Anne's	Duc.	en Ar	ne					1 🗆 Yes 2 🗷 No
	/ith th	ral		adow Ro	n	10f. Z	ip Code	57		10g. Citizen o	f What Coun $\mathcal{S}\mathcal{H}$	try?
	tems	Funeral Director		2. Was Decedent Ever	in U.S.	13. Was Dece	edent of Hispanio	Origin? (Spe	city Yes or No-		ace - Americ	an Indian,
20	ifter d ", or i amin	þ	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give			ecify Cuban, Mex 2 🗷 No Spe		Hican, etc.)		ack, White,	etc.
2-003p	ours a atural cal Ex	Completed	3 X Widowed 4 Divorced 15. Decedent's Educ	Year or Dates.	160	Decedent's Us	<u> </u>			Speci	1310	ack
213	n 72 h a. Medi	du	(Specify only highest grade Elementary/Seconday (0-12)	completed) College (1-4 or 5+)	10a.	(Give kind of w life. DO NOT u	ork done during i	most of worki	ng	16b. Kind of	Business inc	dustry
7	within ygiene.		9	College (1-4 of 5+)	Pr	oduct	ion W	orke	<u>r</u>	Sea	wate	-h
and	should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examiner must be notified at	To Be	17. Father's Name (First, Middle, Last)		_	1 -	18. N	Nother's Name	e (First, Middle, i	Maiden Surnai	me)	
Ž	should be and Me is mark aumatic	ľ	19a. Informant's Name/Relationship (Type		Jaco		ss (Street and Nu	MAN OF BUT	1 Bouto Number	Sro	State 7in C	ay
Ž	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at		Terrance Baile	· · · · · /		_	ar war			-		
e,	of He of He if item		20a. Method of Disposition 1 🛭 Burial 2 🗆 Cremation 3 🗆 R	17 2	20b. Place of	Disposition (Na y, crematory or	ame of	. [le De	20c. Location	n - City or To	wn, State
partimo	t. Page 1 tment of tant: If it ijury or o		Donation 5 Other (Specify)		Sand	town 1	Cem.	10-2	9-2011	14:115	boro	ma.
00	permit. Page 1 Department of Important: If i any injury or o	(21. Signatur Funeral Service Licensee	fol	-	Benra Benra	INC Smi	acility the Fu	neral	Home	2100	
			23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one	cause on each line.					r respiratory arre	est,		Approximate Interval Between
	Pnysician/	Ĭ	Immediate Cause (Final disease or condition	Metasta	tic	bladd	er ca	ncer				Onset and Death
	Medical Examiner		resulting in death) a.	Due to (or as a co	nsequence o	rf):						
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a co	nsequence o	ii).						
	sate be executed physician and the burial-transit	Examiner	Cause (Disease or linjury that initiated events c.									
	be exe iician a burial-	SalE	resulting in death) Last	Due to (or as a co	nsequence o	т):						
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Š	n certii ending r use a	an/N	20b. Was decedent pregnant	c. If yes, outcome of p	regnancy Fetal death	3 🗆 Ectopic	pregnancy			23d. [Date of delive	ery
DOX	e deatl the att hed fo	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at tim g ☐ Unknown		5 Other (٨	/lonth	Day Year
9	hat the ed by detac		Part II. Other significant conditions cont	ributing to death but n	ot resulting in	n the underlying	cause given in F	Part I.	23e. Did to	bacco use co	ntribute to th	e cause of death?
ָר ה	uires t n sign uld be	ed by							1 🗆 Y	∕es 2 □ No	3 🗆 Prob	oably 4 Unknown
Secords,	aw req	plet							24a. Was a autop			osy findings available repletion of cause of
ב ב	The la	Completed							perfor	med? 2 No	death?	
Ō	ician: certific ector,	Be	25. Was case referred to medical examiner?	spital:				Death (Check			Tallad	Hacking Hair
5	Phys rr this e	e: To	1 ☐ Yes 2 ☒ No ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	1 Inpatient 28a. Date of injury	28b. T		DOA Other. 4 [28c. Injury at		me 5 Resid			Hospice House
5	ath. r: Afte	icat	1-⊠ Natural 5 ☐ Pending 2 ☐ AccidentInvestigation	(Month, Day, Ye	<i>ar</i>) in	njury M	work? 1 ☐ Yes		Edd. Dosonbe ni	ow injury cook	anou	
VISIOI	or Atter fter de lirecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp		m, street, facto	ry, office		28f. Location (S City or Town		ber or Rural	Route Number,
5	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical (29a. Certifier 1 Certifying Physici	an: To the best of my	knowledge, o	death occured a	at the time, date	and place, and	d due to the cau	ise(s) and mar	ner as state	d.
	the Ho nin 24 the Fu nplete	Med	(Check 2 ☐ Medical Examine only one) 3 ☐ Certifying Nurse I	r: On the basis of exami	ination and/or	investigation, ir	n my opinion, dea	th occurred at	the time, date ar	nd place, and o	due to the cau	use(s) and manner stated.
	with Con.		29b. Signature and title of certifier Lishmi Vandy an	athan MI	D		lc. License numb			29d. Date sign		Day, Year) L 2011
	'		30. Name and address of person who com LAKSHMI VAIDYA	pleted cause of death	(Item 23a) (1	ype, Print)				MD.	2 16	01
	Stat		31. Date filed (Month, Day, Year) OCT 27 2011	32 Registrar's S	Signature	ha Had)					· · · · · · · · · · · · · · · · · · ·
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State Registrar

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32.

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36657 Certificate of Death 2. Date of Death November 3, 2011 0238 M Physician/ Morris Lee Hall Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Hospital Talbet Easton Memorial Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours (Month, Day, Year) 215-58-5476 60 **Director** 1 🛛 M 2 🗆 F Feb. 16, 1951 Maryland 28a-f show Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Preston Caroline MD 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral 21655 21269 Dover Bridge Road #11 United States 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: Completed 3 - Widowed 4X Divorced Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Printing Press Operator 12 Be and 2 should be filed Health and Mental Hy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Richard P. Hall Gloria Bridges 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Department of Health a Important. If item 27 is any injury or other trainonce. 21261 Tanyard Rd., Preston, MD 21655 Shelley Hall/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2X Cremation 3 Removal from State Cambridge, Maryland 11/04/11 Mid-Shore Crem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. , Federalsburg, MD 21632 216 N. Main St 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) > neumage Medical Die to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or injury r as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 A Yes 2 No 3 Probably 4 Unknown Certificate: To Be Completed Were autopsy findings available prior to completion of cause of cate has by page 2 s autopsy perform death? this certificate Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 🗌 No 1 A Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) nours after death.

neral Director; After the filled in by the funera 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d, Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2 621 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2. Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

ORIGINAL

11-08155 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amanda Elizabeth Hriczko State of Maryland / Department of Health and Mental Hygiene 2011 1- For State Certificate of Death Reg. No Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day October 31, 2011 Medical Examiner Amanda Elizabeth Hriczko 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Caroline Marydel 26704 Temple Road 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Director April 21 1982 2 X F 29 Yrs 1 M 135-76-0446

36658

3. Time of Death 1110 hrs 4c County of Death If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) New Jersey Usual Residence of Decedent 10d. Inside City Limits III 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Maryland Caroline Ridgely . Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Montal Hygiene, retait. If teem 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Modical Exminer must be notified at once Director 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 14685 Cherry Lane 21660 U.S.A. Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No 1 Yes White 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 X No specify: Specify. 3 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 public school sys 6 teacher 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John David Hriczko Rita Mary Swensen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 571 Kings Highway East; Atlantic Island, NJ07716 John David Hriczko/ father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Itimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Nov 7 2011 Stevensville, MD Chesapeake Cremation 4 Donation 5 Other Specify: 22. Name and Address of Facility PO Box 160; Greensboro, MD 21639 21. Signatute of Funeral Service Lie Fleegle and Helfenbein Funeral Home, PA 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Medical Death a. Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical ■ UNPENDED AMENDED attending physician or use as the burial Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 1 Live birth Day Year 3 Ectopic pregnancy Fetal death 2 past 12 months' Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown ξ 9 Unknown isigned by the a 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≲</u> 1 Yes 2 No 3 Probably 4 Unknown Completed has been se 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? this certificate Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 Other: Scene DOA 1 V Yes ဥ 2 No 28d. Describe how injury occurred After 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Certification: Driver ran off road and struck trees Oct 31. 2011 0740 hrs 1 Natural 1 Yes 2 ✔ No Pending death. Director, 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 24 hours a er 3 📋 6 Could not be Suicide or Town, State) 26704 Temple Road, Marydel, MD determined (Specify) Major Road / Highway To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature and title of certifie November 1, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 900 W. Baltimore Street, Baltimore, MD 21223 Assistant Medical Examiner Laron Locke MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36659 Certificate of Death CCHD AJS **AMENDED#5 PER FH** 11/7/11 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Patric 2150 October 1a Low 2011 Medical Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Wicomica Kegional Medical C Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Min Director 1 M 2 X F 27, 1937 Maryland or 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Worcest H: 11 1 🔀 Yes 2 🗌 No Maryland 5 10e. Street and Number ms 23a or must be r 10g. Citizen of What Country? Funeral 21863 hurch USA within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc ō by 1 Never Married 2 Married 2 No Yes Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. "natural". Specify: White Completed 3 Divorced 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) . Hygiene. other than " Elementary/Secondary (0-12) College (1-4 or 5+) driving the Truck Driver Ith and Mental Hygien 27 is marked other to traumatic event, the 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George ate 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 is Willis ٤. 314 S. Church Street, Apt B, Snow Hill, MD 21863 other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Department of H Important: If ite any injury or oth once. 20c. Location - City or Town, State Page 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 11/04/2011 4 ☐ Donation 5 ☐ Other (Specify) Odd Fellows Cemetery anden. Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ipillier anelderlect Chapel-us S. Bredford St. Dove 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) ate has been signed by the attending physician page 2 should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy 5 Other (specify) Month Year Pregnant at time of death Day 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 > Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has performe 1 Yes 2 No Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 X Yes 2 \(\subseteq No Hospita Other: 2 1 Inpatient 2 KeR/Outpatient 3 IDOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred **M**Natural 5 Pending injury Accident
Suicide M 1 Yes 2 🗌 No Investigation within 24 hours a er dest To the Funeral Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medican Examiler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check ractitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and 29d. Date signed (Month. Day, Year) H50497 31/11 and address of person completed cause of death (Item 23a) (Type, Print SALISBUR D. O. 100 E 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar DHMH 17 Rev 06-2011

ORIGINAL

438

			For State	State of Marylan		artment of F tificate of L			0.0	111	26660
			Registrar 1. Decedent's Name (First, Middle, Last)		Cer	uncate of L	Jeani	2. Date of Dea	Reg. No.	4	36660 3. Time of Death
	Physicia		01	Tac1	Jr.			Month 10	Day	Year 2011	9:34 A _M
	Medic Examin		Herman Clarence 4a. Facility Name (if not institution, give st	Jackson reet and number)	21.	4b. City, Town, or	r Location of Death	10	4c. County		, , , , , ,
j	Examili	CI	The John Hopkins I			Baltimor					
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la			If Under 24 Hrs. Hours Min.	8. Date of Bir	th v. Year)	g. Birthp	lace (State or Foreign
	Director		<u>579-54-4657</u>	^{km 2 □ F} 69	Yrs.	World S Days	Tiodio Iviili.	(Month, Da May 3	1 1942		" VA
	or at		Usual Residence of Decedent 10a. State 10b. County	10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	arylar a-fsł fied a	Director	MD Montgome:		ver Sp						1 X Yes 2 ☐ No
	or 28	흅	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Coun	try?
	with t	eral	8708 Colesville R	D. Apt.# 102		20910			United	Stat	es
	leath items er m	Funeral		12. Was Decedent Ever in U.S Armed Forces?	3. 13. \	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - Americ	
36	", or	by	1 Never Married 2 Married	1 Yes 2 XNo		Yes 2x No			Specify		
8	72 hours after death with the Maryland "natural", or items 23a or 28a-f sho Aedical Examiner must be notified at	Completed	3 Widowed 4 Divorced 15. Decedent's Edu	Year or Dates.	16a Deced	dent's Usual Occup	nation		16b. Kind of B	B1a	
5	72 h in "na Medic)du	(Specify only highest grad	e completed)	(Give		during most of work	ing	TOD, KING OF B	usii 1033 1110	300ti y
212	within giene. er thar the N;		Elementary/Seconday (0-12) 12th	College (1-4 or 5+)	Respi	ratory Tl	herapy		Privat	:e	
פ	be filed vental Hygerked other ic event,		17. Father's Name (First, Middle, Last)				18. Mother's Nam	ne (First, Middle,	Maiden Surnam	e)	
ylaı	should be file and Mental F is marked o	욘	Herman Jackson				Sarah W				
lar	ge 1 and 2 should be filed within 72 hours after death with the Manyland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic.	- 33	19a. Informant's Name/Relationship (Typ	e, Print)			and Number or Rur				076
6	and 2 s Health tem 27		Eric Jackson /Son 20a. Method of Disposition	Look F		sition (Name of	Lane, Ha	Date	20c. Location		
Baltimore, Maryland 21215-0036	or of		1 🖁 Burial 2 🗆 Cremation 3 🗆 F	Removal from State	emetery, crer	natory or other plac				•	
Ħ	permit. Page 1: Department of I Important: If it any injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	ρ Mar		National	ess of Facility Po	1/2011 pe Fune	Laure		
Ba	permit Depar Impor any ir	70	A THE CLASS	11-00 MO/05			boro Pike				
			23a. Part 1. Enter the disease, or compl	cations that caused the deat	h. Do not ente	er the mode of dyir	ng, such as cardiac	or respiratory a	rest,		Approximate Interval Between
~	h sician/		shock, or heart failure. List only one Immediate Cause (Final								Onset and Death
	Medical		disease or condition resulting in death)	Due to (or as a consequ	uence of):						
	Examiner	L	Sequentially list conditions,			ous Leuk	emia				
	D #	Examiner	if any, leading to immediate	Due to (or as a consequ	uence of):						
	ecute and -trans	xan	Cause (Disease or iinjury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
	death certificate be executed re attending physician and ed for use as the burial-transit	dical		, , ,	,						
760	cate phys s the	edi									
89	certifi inding use a	N N	23b. Was decedent pregnant	3c. If yes, outcome of pregna 1 ☐ Live Birth 2 ☐ Feta	incy	- Estable pregnan	IOV.		23d. D	ate of deliv	ery
Box 687	requires that the death certifica been signed by the attending p should be detached for use as t	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnant at time of c		Other (specify)			М	onth	Day Year
0.	t the c by th tache	Phy	9 Unknown			un deutstan annan ei	iven in Port I	00 - Did		tributo to t	he cause of death?
, P.O.	s that igned be de		Part II. Other significant conditions cor	ntributing to death but not res	sulting in the t	indenying cause gi	iveirii Fatti.				bably 4 Unknown
rds	equire een s nould	eted			-						psy findings available
000	> 0 0	Completed by						24a. Was	psy	prior to co death?	impletion of cause of
R	r. pag		25. Was case referred to medical			00.5	N (D (Ob-		ormed?	1 Yes	2 No
ital	siciar certif irecto	Be	evaminer?	lospital:	ED/Outratia	Ott	Place of Death (Che		idence 6 🗆 Otl	or (Specif	w
Σ	Physic ruthis eral di	e :	27. Manner of Death	28a. Date of injury	28b. Time o	f 28c. Inju	ry at		how injury occur		<u>//</u>
n C	nding ath. r: Afte e fune	icat	1 Natural 5 Pending 2 Accident Investigation	(Month, Day, Year)	injury	M 1 🗆	Yes 2 No				
Division of Vital Records,	r Atte er de recto by th	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm, sti	reet, factory, office			(Street and Numi wn, State)	per or Rura	l Route Number,
Š	the Hospital or Attending Physician: The law requires that the Mada House and a fact death. The Funerial Director: After this certificate has been signed by the tripleted filled in by the funeral director, page 2 should be detached.										,
	Hosp 24 hou Funer ted fill	Medical	(Chook 2 Modical Evamin	cian: To the best of my know er: On the basis of examinatio	n and/or inves	stigation, in my opin	ion, death occurred	at the time. date	and place, and d	ue to the ca	ause(s) and manner stated.
		M	only one) 3 Certifying Nurse	Practioner: To the best of m	y knowledge,	death occurred at to 29c. Licens		ace, and due to t	he cause(s) and n 29d. Date sign		
	5 V VII		5.57	MA					Novemb		
	وسر		30. Name and address of person who co	empleted cause of death (Iten	n 23a) (Type.	RES-C	JUU		* A 8 - 6 - 7	c ~1	0011
R	. 5		Sean Tackett, M.D.				Baltimore	,Maryla	nd 21287	e Vin	
	Sta		31. Date filed (Month, Day, Year) NOV 0 3 2011	32. Registrar's Sign	ture	-					
	Registr	ar	NOVO 3 ZUII /4	WWW 19. 19							

State of Maryland / Department of Health and Mental Hygiene 2011 Certificate of Death . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Octobe Physician/ 10:15 PM Ernest . Medical L. <u>Jackson</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Doctors Community Hospital Lanham Fühder 24 Hrs. 9. Birthplace (State or Foreign last hirthday If Unde 8. Date of Birth **Funeral** Month, Day, Year 1 🔀 M 2 🗆 F Months Hours Min. Vear Country) Yrs. Director 578-42-8975 June 193 Wash..DC Usual Residence of Decedent or 28a-f show notified at 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MD PG Lanham 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a or ner must be n Funeral United States 20706 7923 Glenarden Parkway 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status the Medical Examiner Armed Forces? Black, White, etc. ö þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2X No Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16h Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Law Enforcement Government should be filed with and Mental Hygier 7 is marked other t permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Jackson Naomi Lomax 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7923 Glenarden Parkway Lanham, MD 20706 Gloria Jackson/wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 11/8^{Date} 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Veterans Cemetery Cheltenham, MD re of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. MD.20746 Silver Hill Rd., Suitland, 23a. Pat/1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Respirator disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any leading to immedicause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 To the Funeral Director: After this certificate completed filled in by the funeral director, pag 2 1 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No 2 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After 5 Pending work? 2 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the unite, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Lankom 8118 Good hack Rd. 32. Registrati Signa 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Leaible.

State of Maryland / Department of Health and Mental Hygiene 20

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			1 - State Registrar	State of Ma	il ylailu / i		tificate of			ig. No.	UII	30002
			Decedent's Name (First, Middle, Last)						2. Date of Deat	n	V	3. Time of Death
	Physici		Myr+1	e Kefau	ver Jo	hns	con		NOV .	Bay	2011	11:30 aMm
	/Medic Examin	_	4a. Facility Name (If not institution, give s		VOI DO			r Location of Deat	1		unty of Death	
		•	Hart He	ritage				Street			Harf	ord
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last bi	thday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	ace (State or Foreign try)
3	Director		186-38-8213	M 2XF	88	Yrs.			Dec. 2,	1922		MD
	and w	}	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Lo	cation				1	Od. Inside City Limits
	Maryi f sho	ĮO.	PA You	a le			Cto	wartsto	:-770			1 ☐ Yes 2 X No
	288-	Director	10e. Street and Number	. κ	· · · · · ·		10f. Zip Code	wal LSLO		0g. Citizen	of What Coun	try?
	3a or		6252 Pleasant	- Valley	Road			17363			U.S.A	\.
	deatl	Funerai		12. Was Decedent E Armed Forces?		13.	Vas Decedent of h	dispanic Origin? (S an, Mexican, Puert	pecify Yes or No-		Race - Americ Black, White,	an Indian,
9	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "natural", or items 23s or 28e-f show event, the Medical Examiner must be notified at	Fu	1 Never Married 2 Married	1 Yes 2 N	0		I □ Yes 2 🛣 No		o 1110a, 010.,	-	ecify:	
8	ural',	d by	3 XWidowed 4 □ Divorced	Year or Dates:	1 40						Wh	ite
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	filed Hygi other	Be C	17. Father's Name (First, Middle, Last)				11011101		ne (First, Middle, M	Maiden Su	mame)	
<u>a</u>	Mental Merked c	To B	Luther M. Kefa	uver				Esther	H. Eas	terd	lay	
Maryland	2 should and Men is marke	0 1	19a. Informant's Name/Relationship (Ty	pe, Print)	198	. Mailir	g Address (Street	and Number or Ru	ıral Route Number,	City or To	own, State, Zip	^{Code)} 17363
	1 and 2 Health 6m 27 i		William C. Joh	nson://S				nt Vall	ey Rd.,			
ore	Peges 1 nent of Hu int: If iter		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 XP	emoval from State	20b. Place of cemete	f Dispo ry, crer	sition (Name of natory or other pla	ce) NO	v. 14,	20c. Locat	ion - City or To	wn, State
Ē	. Peg tmen tent: jury		`4 □ Donation 5 □ Other (Specify)		Stewar		own Ceme	tery 20)11			wn, PA
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23a or 28e-f show any injury or other treumatic svent, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Utcens	7/1								uary, Inc.
			23a. Part 1. Enter the disease, or compli	cations that caused	the death. Do				Stewar		own, P.	Approxim ate
			shock, or heart failure. List only or Immediate Cause (Final	e cause on each line	θ.			<u> </u>				Interval Between Onset and Death
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	Examiner			200 10 (01 23 0	2001304481100	orj.						
	البيدية	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury). Due to (or as a	i consequence	ذان.						
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90,	Attending Physicien: The law requires that the death certificate be executed rideath. rideath. ector: Atter this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit.	EX	resulting in death) cast	Due to (or as a	a consequence	of);						
68760,	cate b physic the b	edicai		1	·							
	certifi iding ise as		IF FEMALE:	3c. If yes, outcome of	of pregnancy					230	I. Date of delive	irv
Vital Records, P.O. Box	atten atten I for u	by Physician/N	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 4 ☐ Pregnant at t	2 Fetal death		Ectopic pregnanc Other (specify)	у		250	Month	Day Year
O.	that the death ted by the atter detached for t	hysi	9 Unknown	9□ Unknown								
ري ت	res that signed to be deta	y P	Part II. Other significant conditions cor	tributing to death bu	t not resulting	in the u	nderlying cause gr	ven in Part I.	23e. Did to	acco use	contribute to the	ne cause of death?
ğ	w require been sig should b								1 □ Ye	s 2 🗖 N	No 3□ Prob	ably 4 Unknown
900	has begge 2 sho	plet							24a. Was a		24b. Were auto	psy findings available inpletion of cause of
<u> </u>	The I	Completed							perform	ned?	death? 1 ☐ Yes	2 No
/ita	icien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	1					ath (Check only on	Θ)		Assisted
	Physi this c	2	1 Yes 2 No	lospital: 1 Inpatier		_	it 3 DOA		lome 5 Reside			1) Cork
L C	ding l	tion	1 ☑Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		Time of Injury	Wa	rk?]Yes 2□No	20d. Describe no	/# injury o	ocurred	
Division of	or Attending Physicien: after death. Director: Atter this certific in by the funeral director.	fica	3 Suicide 6 Could not be	28e. Place of Inju	ry - At home, f	arm, str			28f. Location (SI		lumber or Rura	l Route Number,
2	afor A after i Dire	Certification:	4 Homicide	building, etc	. (Specify)				City or Town	i, State)		
	ospit hours unere		29a. Certifier 1 ☐ Certifying Physical Examination									
	To the Hospitel or A within 24 hours after To the Funerel Direct Completely filled in by	Medical	one)	and manner state	ted.							
	With To	2	29b. Signature and title of certifier	44.0			29c. Licen				igned (Month,	
	2.0		(11) 18/	- 54/)		-	<u> </u>	2100	7	V3 JR1	7/1/	10011
	186		30. Name and address of person who co		3 6/5	(Type,	· MAP	Hoil 1	Bel An	MD	2101	9
	Sta	te	31. Date filed (Month, Day, Year)		r's Signature	.4 4						
161	Registr	ar	NOV 1 6 2011	Vision A	. Ann	Marie Contract of the Contract						

		•	For State Registrar	State of Maryla		artment of H tificate of D			eg. No.	201	1 36663			
	Physicia	in/	1. Decedent's Name (First, Middle, Las Michiyo M. Kwon	,				Date of Deat Month		Year 2011	3. Time of Death			
	Medic Examin		4a. Facility Name (if not institution, give			4b. City, Town, or	Location of Death	October		nty of Death	1:35 P ^M			
-	XGIIII		Shady Grove Adve	ntist Hospita	ille		Mont	Montgomery						
	Funeral Director		212 32 7200	ex □ M 2 🟋 F 7. Age (In yr. 92	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Sept. 3	Year) 1919	9. Birthplace (State or Foreign Country) Japan				
	and show lat	lo:	Usual Residence of Decedent 10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits				
	Maryl 28a-f otified	Funeral Director	MD Montgo	nery	Gaith	ersburg					1 ☐ Yes 2 🔀 No			
	ith the	ralD	10e. Street and Number			10f. Zip Code	378		10g. Citizen o	of What Cou ed St				
	tems ser mus	Fune	160 Golden Ash W	12. Was Decedent Ever in	U.S. 13. \	Vas Decedent of His	spanic Origin? (Spe	ecify Yes or No-	14. R	Race - Amer	ican Indian,			
Maryland 21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ Married 3 🙀 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 🌠 No If Yes, Give Year or Dates.		f Yes, specify Cubar	Specify:	Hican, etc.)		Black, White				
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Baltimore,			20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif	y, MD	Town, State									
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	Ph sician/ Medical Examiner	Examiner		Interval Between Onset and Death										
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ls, P.O	v requires that the state of th	þ	Part II. Other significant conditions of	ontributing to death but not	resulting in the u	nderlying cause giv	en in Part I.				the cause of death?			
Division of Vital Records, P.O.	To the Hospital or Attending Physician: The law requires that the within Lat hours after death. To the Funeral Director, After this certificate has been signed by it completed filled in by the funeral director, page 2 should be detached.	Completed						24a. Was a autops perfor 1 \(\superset \text{Yes}\)	sy med?	prior to c death?	opsy findings available completion of cause of			
tal	cian: Cian: Sertifica	Be	25. Was case referred to medical examiner?	Hospital:			ice of Death (Checi							
Ž	Physi r this o	. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	1 1 Inpatient 2 28a. Date of injury	ER/Outpatier 28b. Time of	nt 3 DOA Othe	4 L Nursing Ho	ome 5 Reside			<u> </u>			
sion o	uttending death. ctor: After y the fune	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b	(Month, Ďay, Year)	injury	M 1 🗆	Yes 2 No				al Route Number,			
DIX.	ital or / Ins after ral Dire led in b		4 Homicide determined	building, etc. (Spec		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or Town						
	the Hospital or Attending Physician: Ihin 24 hours after death. the Funeral Director, After this certific mpleted filled in by the funeral director,	Medical	(Check 2 Medical Exami only one) 3 Certifying Nurs	sician: To the best of my kno ner: On the basis of examina se Practioner: To the best of	tion and/or invest	tigation, in my opinio death occurred at the	n, death occurred a time, date and place	t the time, date ar	d place, and	due to the c	cause(s) and manner stated.			
	2 × 2 5		29b. Signature and title of certifier			29c. License	68080		10/2					
			30. Name and address of person who careesha Jalli, i	completed cause of death (It	em 23a) (Type, F edical C	^{erint)} enter Dri	ve, Rock	ville, M	n 208	50				
	Sta	te	31. Date filed (Month, Day, Year) NOV 0 1 2011	32. Registrar's Sig					-					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 - For State Registrar 36664 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Oct. 26, 2011 Year Barbara Theresa Kramer 1525 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Montgomery Bethesda Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🏻 F Months Min Hours 6 123/1930 578-36-7459 WASH, DC 81 Yrs Director Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified MD Prince George' Hyattsville 1 Yes 2 No Separat ASAID 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 6107 20th Avenue 20782 USA 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Examiner Armed Forces?

1 Yes 2 No Black, White, etc ò þ 1 Never Married 2 Married ge 1 and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. t: If item 27 is marked other than "natural", or or other traumatic event, the Medical Examir Specify: White 1 ☐ Yes 2 No Specify: Maryland 21215-003(If Yes, Give Year or Dates 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)
Homemaker Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Tilden Elam Theresa Popp 19a. Informant's Name/Relationship (Type, Print) ${\sf daughter}$ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa Kramer-Burgess/ 8359 Wagon Wheel Road Alexandria, Va. 22309 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Bemoval from State permit. Page Department of Important: If any injury or Chesapeake Crem. 10/31/201 Beltsvile, Md 4 Donation 🏂 🗌 Other (Speci PHILIPOT S. RIWALDI FUNERAL SERVICE P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Critical aortic stenosis Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Aortic insufficiency Sequentially list conditions Examine Due to (or as a consequence of): cause. Enter Underlying Hypertension Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Day Year 5 Other (specify) Month Pregnant at time of death the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by pneumonia 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? clostridium difficle 24a, Was an has performed? Yes 2 No 1 ☐ Yes 2 ☐ No this certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 XNatural 5 Pending 1 Yes 2 No Investigation Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ID 09468164 11 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kimberly B.Zuzak MD 8600 Old Georgetown Rd Bethesda, Md

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month,

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Registrar's Signat

2011

NOV 01

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36665 State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October Katinas 20 lei Yvette 12:00 P M 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6736 Brigadoon Drive Montgomery Bethesda Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth 1 M 2 XF Months (Month, Day, Year) 86 NH 001-18-9183 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State Yes 2 No MD Montgomery Bethesda 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20817 6736 Brigadoon Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Narried If Yes, Give Year or Dates 1 Yes 2 X No Specify: White Specify: 3 Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Lydia Fecteau Felix P. Corriveau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6736 Brigadoon Dr Bethesda, MD 20817 George Katinas Spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/31/11 Falls Church, VA Crematory 22. Name and Address of Facility Joseph Gawler's Sons 21. Signature of Funeral Service License 5130 Wisconsin Ave NW Washington DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Chronic Obstructive Pulmonary Disease disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a consuluence of Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Year Day 5 Other (specify) Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 V No 26. Place of Death (Check only one)

Physician Medical Examiner Examine

Physician/

Medical

Examiner

Funeral

Director

or 28a-f show notified at

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Funeral

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within 72 hours after

Baltimore, Maryland 21215-0036

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Physician/Medical by Completed Be ည

Medical

IF FEMALE 25. Was case referred to medical examiner? 1 Yes 1 X Natural

29a. Certifier

Certificate:

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: ithin 24 hours after death.

the Funeral Director: Af

mpleted filled in by the fu within 2

To the F

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> State Registrar

2 🔀 No 27. Manner of Death

5 Pending Accident Suicide 4 Homicide

3 🗖

29b. Signature and title of certifie

6 Could not be determined

Investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of

work?

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

iniury

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

28c. Injury at

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 10/28/11

28f. Location (Street and Number or Rural Route Number, City or Town, State)

D 23170

Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify)

28d. Describe how injury occurred

Gita C. Bakshi, MD F.C.C.P. 9404 Old Georgetown RD Bethesda, MD 20814 32. Registrar's Signature

31. Date filed (Month, Day, Year) NOV 0 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36666 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Year Physician/ 04 7:40 A M Ralph Oliver Knight II Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 E1kton Union Hospital 8. Date of Birth If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Min 1 🗷 M 2 🗆 F Months 11/26/194 MD **Director** 69 213-38-9007 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 XYes 2 No Havre De Grace MD Harford 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21078 4401 Colt Lane Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1

Yes 2 □ No Black, White, etc by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Auto Repair Business Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Grace Louise McGreevy John Robert Knight 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Colt Lane, Havre De Grace, MD 21078 4401 Anja Knight – wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 11/6/2011 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.T.Foard Funeral Home, PA Rising Sun, MD 22. Name and Address of Facility 21. Signature of uneral Service License R.T. Foard Funeral Home, PA 21921 259 East Main Street, Elkton 23a. Part 🗜 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between shock, or heart failure. List only one cause on each line. Onse and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or a la consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) Be ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after deatl To the Funeral Director, completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one) 29b. Signature and title of certif 11.4.2011.

State Registrar

15+IVA

30. Name and address of person

SACHDE

Elecon MD21921.

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death

October

6:12 P

29d. Date signed (Month, Day, Year)

MD-21601

Physician	
/Medical	
Examiner	

1. Decedent's Name (First, Middle, Last)

Beatrice

LAKSHMI VAIDYANATHAN

MOVUL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Twila

Keats

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Madical Eventment must be notified at

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached

r	4a. Facility Name (If	treet and nu	4b. City	, Town, o	r Location	of Death		4c. County of Death									
	Carolin	ne Home	e for	r Hos	oice	De	nton					Caroline					
	5. Social Security No		6. Sex		7. Age (In yrs.	last birth	nday) If Under	r 1 Year Days	If Unde Hours	r 24 Hrs. Min.	8. Date of Bi (Month, D March	rth ay, Yea	r)	Co	thplace (State or Fo		
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	10a. State	10b. County			10c. Ci	ity, Town	or Location								10d. Inside City Li	_	
5 │	Maryland	Anne	Arııı	nd1e		Glen	Burnie								1 ☐ Yes 2 💆	7 NO	
3	10e. Street and Nur		111 0.				10f. Z	ip Code				10g. C	Citizen of	What Co	ountry?		
5			Dog	4			210	60				USA					
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5	11. Marital Status 1 Never Marri	o		Armed F	cedent Ever in U orces? 2 🔀 No	,,,,,	If Yes, sp	ecify Cub	an, Mexica	an, Puerto	ecify Yes or N Rican, etc.)		Bla	ack, Whit			
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9	William	m N. T	racy	•									-				
	19a. Informant's Na	ame/Relations	ship (Typ	pe. Print)										n, State, Zip Code)			
	Jack Keats/ son 151							y Ro	ad;	Golds	sboro,						
	20a. Method of Disp	Disposition (N	osition (Name of Date 20c. Location - City or Town, State smatory or other place)														
	1X Burial 2		.11 Cemetery Nov. 2 2011 Baltimore, Marylan														
	21. Signature of Funeral Service Licensee 2 22. Name and Address of Facility PO Box 160; Greensboro, MI																
	Fleegle and Helfenbein Funeral Home, PA																
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	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													Interval Betwee	en ath		
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	resulting in death)		a a		emen o (or as a conse												
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	cause. Enter Under Cause (Disease or that initiated events	erlying - injury	۲														
xa	that initiated events resulting in death)	s Last	С	Due to	o (or as a conse	quence	of):										
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State Registrar

DHMH 17 Rev 1/2001

Medical

1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

219 S. WASHINGTONST EASTON

DO 57749

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36668 for State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month ber 2011 Physician/ Mary LoBianco Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie 8. Date of Birth (Month, Day, Year July 27 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) If Under 1 Year If Under 24 Hrs. Social Security Number **Funeral** Min. 1 □ M 2 🕱 F Months Days Hours Washington. Director 579-42-4675 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State with the Maryland the Medical Examiner must be notified at Director 1 Yes 2 X No Gambrills Anne Arundel Maryland 10g. Citizen of What Country? 10f. Zip Code 9 10e. Street and Number items 23a Funeral U.S.A. 21054 477 Saint Barbara Lane death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced White. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Metropolitan Police than Elementary/Seconday (0-12) College (1-4 or 5+) Department Administrative Aide and Mental Hygie is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Rose Mary Arcuri Page 1 and 2 should be Natale Anthony LoBianco 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 2705 Apple Way, Dunkirk, Maryland 20754 Jo Girardi - Sister 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 11/05/2011 Silver Spring, Maryland 4 ☐ Ponation 5 ☐ Other (Specify) Gate of Heaven Cem. 21. Si ha ure of Funeral Service icensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. M00209 Janes 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final neumonia Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner e attending physician and To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 month Month Day Other (specify) Pregnant at time of death g 🗍 Unknown has been signed by the 23e. Did tobacco use contribute to the cause of deam? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 1 Yes 2 No After this certificate 2 1 25. Was case referred / medical 26. Place of Death (Check only one) Certificate: To Be examiner? 2 No Hospital: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manuer of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at work? Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after deat To the Funeral Director: 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who 05 P UVVIL en 31. Date filed (Month, 32. Registrar's Sigrature State

Registrar

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NOV

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 2041 M Physician/ LAPADYLA 2011 SCHAL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Anne Arundel Medical Center Annaplois 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year Funeral Months Davs Hours Director 212-20-1625 1 **Z**M 2 □ F 87 March 5, 1924 NY Usual Residence of Decedent 28a-f show 10d. Inside City Limits aţ 10a. State 10b. County 10c. City. Town or Location with the Maryland Director er than "natural", or items 23a or 28a-f s the Medical Examiner must be notified MD 1 Yes 2 No Anne Arundel Annapolis 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 1 Severn Court 21403 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican. etc.) Armed Forces?

1 🖾 Yes 2 🗌 No 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 72 hours after Specify:White 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates. WWII Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Attorney Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name /First Middle Last. permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or cert ဂ္ Michael Joseph LaPadula Constance Paradise 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan L. Buckingham/Daughter 1 Severn Court, Annapolis, MD 21403 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Nov. Gate of Heaven Cemetery Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Francis Adress Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring 21. Signature of Foneral Service Lice MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between ACUTE Unset and De th Immediate Cause (Final KESAR ATORY Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner 5 DIRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine 1 DEMENTIA Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed and Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death the signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No has To the Hospital or Attending Physician: 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director; After to completely filled in by the funer iniury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

ONUM 30 2011 29b. Signature and title of certifier 29c. License number 21438 10+1 30. Name and address of person who completed suse of death (Item 23a) (Type, Print) ANNAPOLIS MOLIYO DEFENSE

State

Registrar

31. Date filed (Month, Day, Year)

NOV 0 1 2011

32. Registrar's Signature

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person

Box 68760

P.O.

Division of Vital

LARGO NO 20774

cause of death (Item 23a) (Type, Print)

9200 BASIL CT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

			for State Registrar	State of	Marylan		artmer <i>tificat</i>			nd Me		giene Reg. No.	201	366	7			
	Physicia	n/	1. Decedent's Name (First, Middle	, Last)							2. Date of Dea		Year	3. Time of Death)			
	Medic	al	SANDRA I 4a. Facility Name (if not institution	ELLEN LANE							OVEMBE	R I	2011	22:30 P	M			
	Examin	er	UNION HOSPITAI	7		LKTO	Location of D	Death		4c. County of Death CECIL								
	Funeral Director		5. Social Security Number		. Age (In yrs. I		If Under		If Under 24	4 Hrs.	8. Date of Birt (Month, Day FEB • 8	h	9. Birth	place (State or Forei otry) YLAND	ign			
	*		215-76-1514 Usual Residence of Decedent		60					11	ED. O	1931			_			
	ryland -f sho ied at	ctor	10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limi				
	or 28a	Dire	MARYLAND CECT 10e. Street and Number	<u>[L</u>	PC	ORT DEF	OSIT 10f. Zip	Code				10g Citizen	of What Cou		NO			
	with the same same same same same same same sam	Funeral Director	9 BIRCH COURT						904			UNITED STATES						
336	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	by	11. Marital Status	1 ☐ Never Married 2 ☐ Married Armed Forces? 1 ☐ Yes 2 ☒ No					spanic Origin n, Mexican, F Specify:	n? (Speci Puerto Ri		14. Race - American Indian, Black, White, etc. Specify: WHITE						
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7	iled wit I Hygie other vent, th	Be C	8 17. Father's Name (First, Middle, I	ast)		APPAF	REL S	ALES			First, Middle,		TAIL_					
Jan	d be fil dental rrked o	읻	JOHN HUSS								RRIGAN	maracir our	raine)					
Maryland	1 and 2 should be filed v f Health and Mental Hyg item 27 is marked othe other traumatic event,	19a. Informant's Name/Relationship (Type, Print) JOHN LANEY / SON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State of Street and Number of State of Street and Number of State of Street And Number of State of State of S												Code) 904				
baltimore,	of Heal		20a. Method of Disposition 1 ✓ Burial 2 ☐ Cremation			Place of Dispo	sition (Nar	ne of	NO	OVEMI			ion - City or T					
Ĕ	permit. Page 1 Department of Important: If it any injury or o		4 Donation 5 ☐ Other (S	pecify)	late	BURY CE	EMETE	RY	4,	, 201	11			T,MARYLAN	D			
E D	permi Depar Impor any ir		21. Signature of Javeral Service	irensee		-					CH FUNE ET,NORT			.A. LAND 2190	1			
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	Medical Examiner		resulting in death)	Due to (or	as a consequ				EASE					YEAKS				
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DOX 001	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompleted filled in by the funeral director, page 2 should be detached for use as	by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 23d. 2								. Date of deli Month	Date of delivery Month Day Year						
	that the	by Ph	Part II. Other significant condition	ons contributing to dea	th but not res	ulting in the u	nderlying (cause giv	en in Part I.				_	the cause of death?				
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VILAI	ysicial s certi	To Be	examiner? 1 Yes 2 No	Hospital:	natient 2 🗆	ER/Outpatien	t 3 1 D	Otho	er:		ne 5 🗆 Resid	lence 6 \square	Other (Specia	ivi	_			
5	fing Phy T. After thi funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of (Month,		28b. Time of injury	2	8c. Injury work	at ?	28	3d. Describe h							
DIVISION	al or Attences after death	Certificate:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Place of	Injury - At ho , etc. <i>(Specify</i>	ome, farm, stre	M et, factory		Yes 2□N	-	8f. Location (S City or Tow		umber or Rura	al Route Number,				
	e Hospit 24 hour e Funera	Medical	(Check 2 L Medical E	Physician: To the bes xaminer: On the basis Nurse Practioner: To	of examination	n and/or invest	igation, in i	my opinio	n, death occu	urred at th	ne time, date a	nd place, and	d due to the c	ause(s) and manner s	tated.			
	To the within	~	29b. Signature and title of certifier				290	. License	number			29d. Date si	igned (Month,	Day, Year)				
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	3			304-306 W				七世	3 EL	hTUn	MAI C	CLUM	0 310	121				
	Stat Registra		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signat	ture &												

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month LEDNUM 2144 October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Hospital Talbot Easton Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours 215-44-6916 **Director** 1 □ M 2X F Sept. 2, 1943 Maryland 68 Usual Residence of Deceden 28a-f show the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 □ No <u> Maryland | Caroline</u> Denton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 503 Caroline Apartments U.S.A. 21629 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 ₩ Widowed 4 □ Divorced 'natural", Specify: Completed White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 10 Homemaker Family Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Norman Alton Timms Dora Catherine Allen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Barbara Jo Messick/daughter 4651 Bethlehem Road Preston, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗆 Burial 2 🗶 Cremation 3 🗆 Removal from State 10/29/2011 Dover, Delaware Capitol Crematory 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service 22. Name and Address of Facility Moore Funeral Home, P.A. 12 South Second Street Denton, Maryland 21629 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ RESPIRATORY disease or condition Medical resulting in death) Examiner TILMONARY DISCHOOS CHRONCE OBSTRU CTIVE Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): burial-tra Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death g | Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by or Attending Physician: The law requires CARDIO MAS CULAR 1 XYes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of MOUNTES 24a. Was an has page 5 autopsy performed? Yes 2 N death? HYPERLIPIDEMIA after death.

Director: After this certificate filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DOOK 7509 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar VAMOS

31. Date filed (Month, Day, Year)

DAFFIN

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36673 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:48aM David Wayne McGraw October Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Holy Cross Hospital Silver Spring Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) Months Director 497-58-5625 59 1 X M 2 . F 09/06/1952 Virginia 28a-f show at 10b. County 10c, City, Town or Location with the Maryland **Funeral Director** be notified 1 Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? ral", or items 23a Examiner must be 4009 Postgate Terrace. 20906 u.s.A. permit, Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 X No
If Yes, Give Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗶 No Specify: Completed 3 Divorced White. Year or Dates artment of Health and Mental Hygiene.
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injury or other traumatic event, the Medical! Decedent's Education 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business/Industry (Specify only highest grade completed) life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Own Business 5+ Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ John McGraw Marguerite Annofsky 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Wilhelm - Sister 920 Spring Hill Court, Kernersville, NC 27284 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of F Important: If ite any injury or oth 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/01/2011 Baltimore. Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Years Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner Das to for sels consequence of fair, leading to in necta cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Dav Pregnant at time of death 2 No 9 Unknown 9 Hinknown Division of Vital Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sepsis, Severe Dehydration, Renal Insufficiency 1 Tes 2 No 3 Probably 4 Lunknown Completed Huperkalemia 24a Was an 24b. Were autopsy findings available certifica e has prior to completion of cause of death? autopsy performe 2 🗌 No Yes 2 X No 1 Tes To the Hospital or Attending Physician: a within 24 hours after death.

To the Funeral Director. After this certifica completely filled in by the funeral director, to 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 2 **X**No Other: 1 🗌 Yes မ 1 Inpatient 2 X ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 53 D0043539 October 26, 2011 30. Name and addre ss of person who completed cause of death (Item 23a) (Type, Print) 1500 Forest Glen Road, Silver Spring, Maryland 20910 Raymond White, M.D.

State

Registrar

NOV 0 1 2011

			For State	State of Ma	aryland		artment tificate			nd M		_	20	1 1	366	71
			Registrar 1. Decedent's Name (First, Middle, Last))		061	lineate	OI D	Jaur	Т	2. Date of De	Reg. No	<u>. 20</u>		3. Time of De	
	Physicia Medio		Constance 1	_			_		10-26-			/ear	829 P	М		
	Examin	er	4a. Facility Name (if not institution, give s 29467 Stoney Ridge		4b. City, To	wn, or Li ston		Death		40	c. County of Talb					
	Funeral		Social Security Number 6. Sec.	7. Age	(In yrs. las	t birthday)	If Under 1	Year_	If Under 2 Hours	4 Hrs. Min.	8. Date of Bir			9. Birthp	lace (State or Fo	oreign
	Director		215-36-0001 1 L] M 2 🛛 F	71	Yrs.	Months	Days	Hours	IVIII I.	03-13-	194	0	Country) MD		
	and show fat	or	10a. State 10b. County		10c. City,	Town or Loc	ation			_				1	0d. Inside City L	imits
	Maryl 28a-f otifie	Director	MD Talbot	aston									1 Yes 2	X No		
	ith the 3a or t be n	ral D	10e. Street and Number				10f. Zip C						itizen of Wh	at Coun	try?	
	ems 2	Funeral	29467 Stoney Ridg	12. Was Decedent E Armed Forces? 1 \(\subseteq \text{ Yes} \(2 \subseteq \text{ X} \)	ver in U.S.	13. V	Vas Deceden	601 t of Hisp	anic Origi	n? (Spe	cify Yes or No-		USA 14. Race -	Americ	an Indian,	
36	after de ", or it amine	by	1 Never Married 2 X Married	1	Yes, specify			Puerto F		Black, Specify:	White, 6					
21215-0036	ours a atural cal Ex	Completed	3 Widowed 4 Divorced 15. Decedent's Edi		ent's Usual C			_		16b	Specify: White 16b. Kind of Business Industry					
215	in 72 h e. nan "n Medi	ldmo	(Specify only highest grad		+)	(Give k	ind of work of NOT use re	lone dur	100.1	ob. Raid of Edsiress industry						
121	d with lygien ther th nt, the	a)	Elementary/Seconday (0-12)			Supe	rvisor							ıufa	cturer	
Maryland	be file ental H ked o	To E	17. Father's Name (First, Middle, Last) Arthur Dobson, Sr	•							(First, Middle,		Surname)			
ary	hould and M is mar iumati		19a. Informant's Name/Relationship (Typ			19b. Mailin	g Address (S	treet and			Route Numbe		or Town, Sta	te, Zip Code)		
Σ,	and 2 s Health s tem 27 other tra		James L. McNeal	(Husband)	_				Ridge	Ci	cle E					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ I		cer	netery, crem	sition (Name natory or othe	r place)			ate		_ocation - C		wn, State	
altin	mit. Pe bartme bortan r injury		4 ☐ Donation 5 ☐ Other (Specify, 21. Signature of Funeral Service License		Wood		Mem. P				L-2011		aston,		- D A	
m	permit Depar Impor any in		JOHN R.	MERC	FRE		00 S.	Harı	rison	St	ceet E	am ast	on MD	216	ome P.A 01	
্ৰ	Physician/ Medical		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)	a. PANCE	EAT	c (r respiratory ar		TASIS		Approximate Interval Betwee Opset and Dea	ath
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-	P #	iner	if any, leading to immediate cause. Enter Underlying	Due to (or as a			450/4								10 . 0 .	
	icate be executed g physician and is the burial-transit	Examiner	Cause (Disease or linjury that initiated events resulting in death) Last	Due to (or as a	ı conseque	nce of):								+		
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876	tificate ing phy as the		IF FEMALE:								,					
P.O. Box 687	ath cel attend for use	cian/	in the past 12 months?	3c. If yes, outcome of 1 ☐ Live Birth 3 4 ☐ Pregnant at	2 🗌 Fetal o	death 3	Ectopic pre					ĺ	23d. Date Mont		ery Day Yea	r
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, P.	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours aller death. To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/M	Part II. Other significant conditions con	tributing to death bu	ut not resulf	ting in the u	nderlying cau	se giver	n in Part I.						ne cause of deat	
rds	require been s should	eted	-								24a. Was				osy findings ava	
ec	ne law e has age 2 s	dwo									auto	psy ormed?	pri de	or to co	mpletion of caus	se of
a H	ian: Th		25. Was case referred to medical examiner?					26. Plac	e of Death	(Check	1 🗌 Yes only one)	2 (1)	No 1 I	_ Yes	2 No	
₹	Physician: The law this certificate has al director, page 2	욘	1 ☐ Yes 2 🔀 No				t 3 🗆 DOA	Other:	4 □ Nur		ne 5 🗶 Resi)	_
0 0	ding f th. After funer	cate	1 X Natural 5 Pending 2 Accident Investigation	28a. Date of injur (Month, Day,		8b. Time of injury	M 28c.	Injury a work? 1 \(\sum \) Ye	ıt es 2∐l		8d. Describe l	now inju	iry occurred			
Division of Vital Records,	r Atter er dea rector by the	Certificate:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Inju- building, etc.	ry - At hom	e, farm, stre	et, factory, o	ffice			28f. Location (or Rural	Route Number,	
ā	pital o															
	e Hos 24 hc e Fune	Medical	29a. Certifier (Check 2 Medical Examin only one) 3 Certifying Nurse	er: On the basis of ex	amination a	ind/or invest	igation, in my	opinion,	death occ	curred at	the time, date	and plac	e, and due t	o the car	use(s) and manne	er stated.
	To th Vithii To th Comp		29b. Signature and title of certifier		1.6)	29c. L	cense n	umber	1		29d. D	ate signed (Month, i	Day, Year)	
			* Clucalina	ken l	M			200	6660	14		10	1271	20	/1	
	6		30. Name and address of person who co	022		3a) (Type, P 41307		出	+	ST.1	MICHAE	7.5	am.	2	11663	
	Stat	e	31. Date filed (Month, Day, Year) 1 20	32. Registra			2. 4. 1									
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DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36675 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ OCTOBER 25,2011 Year 12:42P MADELINE MILLER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 5. Social Security Number 6. Sex Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🏋 Hours 09/10/1923 Director 215-66-8066 88 MD Usual Residence of Decedent show 10a. State ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No MD Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral Page 1 and 2 should be filed within 72 hours after death with 110 Burgess Hill Way, #312 USA 21702 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Armed Forces?

1 Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Specify: 3 Widowed 4 Divorced Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ other traumatic James Polk Elkins Helen Fawley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 i Nathan Miller, Jr./son 4367 Old County Rd., Morrisville, NY 13408 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Forest Oak Cemetery 11/05/2011 Gaithersburg, MD Signature of Funeral Service Lice 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease shock, or heart failure. or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest to only one cause operach line. Approximate Immediate Cause (Final P ician/ disease or condition Medical resulting in death) (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a consequence of burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death the 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an the Hospital or Attending Physician; The law has autopsy To the nospone.

Within 24 hours after death.

To the Funeral Director, After this certificate h 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital Other: 1 🗌 Yes မ ER/Outpatient 3 DOA 1 Inpatient 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination on, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Configure Nurse Practioner: To the best of only one) ly knowledge, deat occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature use of death (Item 23a) (Type, Print) 30. Name and address of person who completed of 0 3**0**0 West 9th Street, Kaufmann, Frederick, MD 21701

DHMH 17 Rev 7/2009

State Registrar

				#1 - vd Pleas alth Dept-11/1 1-For Amend Items Registrar	e Type or Pr	int in l	Black In	delibl	le Ink	c. Ens	ure A	II Copie B ^{ntal} Hy	s Are	e Legi	ble.	36	676
ı				1. Decedent's Name (First, Middle, L					3 01 L)eatri		2. Date of De	eath			3. Time of D	
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		Examin	er	4a. Facility Name (if not institution, gi	ive street and number)			4b. City,	Town, or E1k1	Location	of Death			c. County o	f Death		
	-	Funeral		Union Hospital 5. Social Security Number 6.		ge (In yrs. Ia	ast birthday)	If Under	1 Year	If Under		8. Date of Bir	th			ace (State or I	oreign
		Director	231-44-2829 1									y, rear	1932 Country) Virginia			а	
		show	or	Usual Residence of Decedent 10a. State 10b, County		10c. Cit	y, Town or Loc	ation							10	d. Inside City	Limits
		Maryla 28a-f s otified	rect	Maryland Cecil		E	lkton									1 🗆 Yes 2	∑ No
		h the	Funeral Director	10e. Street and Number				10f. Zip					•	itizen of WI			
		ath wit	nner	334 Casparus Way	12. Was Decedent	Ever in II 9	S 13 W	Jas Deced		921	igin? (Spe	cify Yes or No-		nited States 14. Race - American Indian,			
(0	er de	by F	1 Never Married 2 Married	Armed Forces' 1 ☐ Yes 2 😿	?	If	Yes, spec	ify Cuba	n, Mexicar	n, Puerto I	Rican, etc.)		Black, White, etc.			
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	baitimore, maryland 21215-0036	uuld be d Men marke maric	_	Emmett Winburn C								ryant		- 01	. 7: 0		
	Z	2 sho lith an 27 is r traul		19a. Informant's Name/Relationship Wilbert Minor/Hu				_				Route Numbe		r 10wn, Sta 921	ate, Zip C	ode)	
	e,	1 and of Hea item		20a. Method of Disposition			Place of Disposemetery, crem	sition (Nan	ne of	1	-	ate	20c. i	ocation - 0	City or To	wn, State	
	Ĕ,	Page ment tant; It ury or		1 X Burial 2 ☐ Cremation 3 4 ☐ Ponation 5 ☐ Other (Spe			ley UMC	Cemete	ery	1		5, 2011				yland	
-		permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: I fire I is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signative of Funeral Service Lice	ensee 0	. 1	22	Name an	d Addres	s of Facilit	ty Hi	cks Hor	ne f	or Fu	nera		A .
				23a. Part 1, Enter the disease, or co	implications that cause	ed the deat						Street .	_	kton,	МД	21921 Approximate	
8	P	nysician/	100	23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final		2 1	/	Bowe	1 Ob	struc	tion					Interval Between Onset and De	
		Medical Examiner		disease or condition resulting in death)	Due to (or as		uence of):	17-9	7				-				
8		Examine	er	Sequentially list conditions,	b. — Due to (or as		- 6						L	/_	_		
	3	and -transit	Examine	Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Sub-sc (or as	r o coi insop	RETRIES ONLY			(1.1	M. Luce	DICALEX	AMINER			
		executed an and rial-transif		that initiated events resulting in death) Last	C. Due to (or as	a consequ	uence of):			CERTIFIC	CATIONAP	KONFALL					
ç	2	are be physici the bu	dica		d												
000	חס/סס אחם	oding p	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom-	e of <u>pr</u> egna	ncy _							23d. Date	of delive	rv	
	S S	e atter d for u	sicia	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live Birth 4 ☐ Pregnant 9 ☐ Unknown	at time of o		Ectopic p Other (sp		У				Mon		Day Ye	ar
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		Attenting Frigstolan; the street Attention of the funeral director, page by the funeral director, page	icate	1 Natural 5 Pending 2 Accident Investigat	(Month, D	ay, Year)	injury	м	work	Yes 2	- 1	Describe	TIOW III Jo	ny ocounto			
\mathcal{L}	DIVISION	fter de irecto n by th	Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	28e. Place of Ir	jury - At ho tc. (Specify	me, farm, stre	et, factory	, office			28f. Location (City or To			r or Rurai	Route Numbe	r,
ال ق	5	ours a leral D		29a. Certifier 1 Certifying PI	hysician: To the best of	if my know	ledge, death o	ccured at	the time	date and	place an	d due to the c	ause(s) a	and manne	r as state	d.	
H	100	to use mosture of Attentioning Proyecteds: The raw requires that the death definitions be ex- within 24 hours affected ceath. To the Funeral Director, Affer this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	Medical	(Check 2 Medical Exa	miner: On the basis of urse Practioner: To th	examination	n and/or invest	igation, in	my opinic	on, death o	ccurred at	the time, date	and place	e, and due	to the cau	ise(s) and mani	ner stated.
	- 5	Withi Com	_	29b. Signature and title of certifier	B An.	-1		29c	License	number 3	23	+	29d. D	ate signed	(Month, I	Day, Year)	
				30. Name and address of person wh	o completed cause of	death (Ita-	23a) /Tima D	rint)	, 100					1/3/	11		
		8		JAGO DAG	26	00 6	123a) (Type, P	. Ac	4	22	5/20) Wh	url	c 12	~_		
	Ц	Stat Registra		31. Date filed (Month, Day, Year)	201 32. Regist	rar's Signa	ture 8. 4	bark	1								
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36677 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ CHARLES November 10, 2011 STEVEN MCKEMY 11:44 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Westminster 384 Winged Foot Dr. 5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1**X** M 2 □ F Months Days Hours 1072371954 Director 57 214-58-9701 Usual Residence of Decedent , Department of Health and Mental Hyglene. Important: If item 22a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Westminster MD Carroll 1 XYes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral USA 21158 384 Winged Foot Drive 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black White etc. Completed by 1 Never Married 2X Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) independent contractor computers permit. Page 1 and 2 should be filed witi Department of Health and Mental Hygler Important: If item 27 is marked other i Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Leon McKemy Joan C. Blevins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Pamela McKemy/wife 384 Winged Foot Drive, Westminster, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/14/2011 Finksburg, MD Evergreen Mem. Gard. 22. Name and Address of Facility Pritts Funeral Home & Chapel 21 Signature of Funeral Service License 412 Washington Road, Westminster, MD 21157 23a. Pan T. Enter the disease, or complications that cause The death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final) Physician/ Due to (r as a consequence of): disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or injury death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): -bunialphysician sthe burial Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death P.O. I s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed⁴ 2 **N**0 1 Yes Yes 2 2 e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certificieted filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier completed (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00043274 10 2011 ONCOLOGIST 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROBERTO MARTINEZ MO 2401 WEST BELVEDERE AVE, BALTIMORE MD 21215

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year) NOV 1 6 2011

32. Registra 's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36678 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ PATSY ANN NESTOR OCTOBER 20 Year 5:50 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death FREDERICK

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Min. | Month, Day, Y
Dec. II, FREDERICK FREDERICK MEMORIAL HOSPITAL 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F 1932 Virginia Director 225-34-0932 78 Usual Residence of Decedent 28a-f shov 10a, State 10b. County iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No <u>Maryland</u> Frederick Ijamsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9370 Reichs Ford Road 21754 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 27 is marked other than "natural", traumatic event, the Medical Exa Specify: 3 Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) 12 Clothing/ Textile Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marken any injury or and Moyer Hennesey Ruth Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Nestor/ Son 804 Pine Avenue, Frederick, Maryland 21701 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🗌 Burial 2 🗵 Cremation 3 🗌 Removal from State 4 ☐ Donation, 5 ☐ Other (Specify) Stauffer Crematory Inc. 10/31/11 Frederick, Maryland. Signature of Funeral Service 22. Name and Address of Facility
Stauffer Funeral Homes P. A.
1621 Opossumtown Pike, Frederick, Maryland 21702 Part 1. Enter the disease, or complication; if it caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ CAROLOMYOPA THY disease or condition resulting in death) 5 YKS Medical Due to (or as a consequence of **Examiner** Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last Due to (or as a consequence of): physician a the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month 4 ☐ Pregnant at time of death g ☐ Unknown the g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Sq. Records, BREAST CANCER, COPD, MOVEMENT DIMEN Completed 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 No prior to completion of cause of death? 1 Yes 2 No of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural (Month, Day, Year) 5 Pending Division Accident
Suicide 1 Yes 2 No Investigation within 24 hours after death

To the Funeral Director, and completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Hamicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier melson 121936 19 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS VOHINSON DR. FREDERICK, MD 21702 65C ANDEEN DONELYON MD

DHMH 17 Rev 7/2009

State Registrar 32. Registrar's Signatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #23e Per PHY 6922 12/22/2011
State of Maryland / Department of Health and Mental Hygiene For State Registrar 36679 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October. Physician/ 1155 AM Powe11 22 200 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hyattsville St. Thomas More If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex. 1 A M 2 □ F **Funeral** 7. Age (In vrs. last birthday) Days (Month, Day, Country) MS Hours Min 426-84-3966 Yrs 941 Director 69 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 X Yes 2 No Germantown MD Montgomery 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20874 18889 Waring Station Rd #419 USA items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) n "natural", or item ledical Examiner n 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1384 1 ☐ Yes 2 X No Specify: Black Specify: 3 Wildowed 4 X Divorced Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed Graphic Designer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ဂ Cooperwood Eddie Lee Watkins Lottie Mae 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18889 Waring Station Rd. #419 Germantown, MD 20874 Lona Johnson/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Arlington National Cem 11/28/2011 Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall-March Funeral Home 4217 9th St. NW Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER Physician PHARUNGEAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Paris Paris Exami Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of) resulting in death) Last the burial attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? jo Month Day Year Pregnant at time of death Yes 2 No the 9 Unknown detached g Unknown ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>م</u> ANemia No Probably 4 Unknown 1 \square Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas page 2 autopsy performed Yes 2 k death? certificate l 1 ☐ Yes 2 ☐ No director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **K** No ပ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 I DOA To the Hospital or Attending Physical Within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No Natura! 5 Pending Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 01052 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) usbury Ral Hyattsville AND 20781

State Registrar DeVone

31. Date filed (Month, Day, Year) NOV 0 1 2011

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32. Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36680 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 12:05 PM 2eiy tu October Medical Eacility Name (if not institution, give street and number 4b. City or Location of Death 4c. County of Death **Examiner** JUNNS TOPKINS 8 Date of Birth (Month, Day, Year Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs 9. Birthplace (State or Foreign Sex **Funeral** 79 Hours 397-28-5542 **XX**_{M 2} □ F Director uly 15, 1932 Wisconsin works 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland notified at Director Frederick Frederick Maryland 28a-f XX Yes 2 No 10f. Zip Code 21701 10g. Citizen of What Country? 10e Street and Number ms 23a or must be n Funeral 707 Fairview Avenue USA death v items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Was Deceue... Armed Forces? Ves 2X No 14 Race - American Indian 11. Marital Status the Medical Examiner Black, White, etc. ō 1 Never Married 2 X Married þ permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin 1 ☐ Yes 22 If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ Education College Professor 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 John Popenfus Mae Loscher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21701 707 Fairview Avenue, Frederick, Maryland Karen Popenfus - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2XXCremation 3 Removal from State Frederick, Maryland 10-31-2011 Crematory ! 4 Dynation 5 Other (Specify) Stauffer 22. Name and Address of Facility Stauffer Funeral Home 21. Sign ure of Funeral Service 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Ph, sician/ Medical resulting in death) Due to (or as a o nsequence Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day Pregnant at time of death signed by the aid Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe Yes 2 cate has page 2 s this certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific 25. Was case referred to medica completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No ဂ္ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature an 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

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Registrar

31. Date filed (Month

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egistrar's Signature

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600 Month Wolfe St. Baltimore Mary Land 21587

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1	Physicia	ın/	1. Decedent's Name (First, Middle,							2. Date of Dea Month October		Year	3. Time of Deat	
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	Examin	er	Lorien Life Ce		,		45. 01.9, 101	Mt.			1	Frede	rick	
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	within 72 hours after death with the Maryland grene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	Funeral D	10e. Street and Number 713 Midway Ave.	, Apt.#326	5		10f. Zip Co	217	71		10g. Citizen of Unit	ed St	ates	
	death item		11. Marital Status	12. Was Deceder Armed Forces	. 0	3. 13.	Vas Decedent f Yes, specify (of Hispani Cuban, Me	c Origin? (Spe xican, Puerto	cify Yes or No- Rican, etc.)		ce - America		
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship Elaine Lazzaro	1 //	er					Route Number	-		ode)	
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	To the Hospital or within 24 hours after To the Funeral Director Completely filled in		29a. Certifier 1 Acertifying F	hysician: To the best	of my knowl	edge, death o	occurred at the	e time, date	e and place, ar	nd due to the ca	use(s) and ma	nner as state	ed.	$-\dagger$
	he Ho in 24 h he Fur pletely	Medical	(Check 2 Medical Ex	aminer: On the basis of lurse Practitioner: To	f examination	and/or invest	igation, in my	opinion, dea	ath occurred at	the time, date a	nd place, and d	lue to the cau	use(s) and manner	stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ RUSSELL PEARSON Medical 4a. Facility Name (if not institution, give street and number) **Examiner** FREDERICK MEMORIAL HOSPITAL . Age (In yrs. last bir **Funeral** 1. M 2 □ F Director 045-42-9553 Usual Residence of Decedent 23a or 28a-f shov 10a. State traumatic event, the Medical Examiner must be notified at Director 10c. City, Tow MD Frederick 10e. Street and Number Completed by Funeral 6350 S. Clifton Rd. permit. Page 1 and 2 should be filed within 72 hours after death N Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. 11. Marital Status med Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a Elementary/Seconday (0-12) College (1-4 or 5+) coBe 17. Father's Name (First, Middle, Last) ဂ္ James W. Pearson 19a. Informant's Name/Relationship (Type, Print) 19t Helen ₹earson (Wife) 6

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egnancy Fetal death	2 🗆	Ectopio	pregnanc	.,				23d. Da	ate of de	livery	
e of death		Other (st		у				M	onth	Day	Year
t resulting in	the un	derlying	cause giv	en in Part	1.	23e. Did	tobaco	co use con	tribute to	the cause of c	leath?
							Yes	0 🗆 N=	ء 🗆 ۵	mahanhir d	Unknous
						1	res	2 ∐ No	з 🗆 Р	robably 4 💢	Unknown
						24a. Was		24b.	Were au	topsy findings completion of o	available
						_ perf	opsy		death?		ause UI
			00.5		41- /C'	1 Yes	2 🔀	No	1 🗌 Ye	s 2 🗆 No	
			26. Pla		tn (Checi	k only one)					
2 ER/Outp		3 🗆 D	DA Othe	". 4 □ Nı	ursing Ho	ome 5 🗌 Res	idence	6 Oth	ner (Spec	cify)	
28b. Tir inj	ne of ury	2	8c. Injury work			28d. Describe	how in	njury occur	red		
1 '			4								

2. Date of Death

3. Time of Death

Physician/ Medical Examiner Physician/Medical Examiner

To the Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

Immediate Cause (Final

disease or condition

resulting in death)

20a. Method of Disposition

1 🗆 Burial 2 🔀 Cremation

Donation 5 D Other (Specify)

IF FEMALE:
23b. Was decedent pregnant
in the past 12 months?

23c.	If	ves.	out	tcome	of	pre	onar
	4		ivo	Birth	2	\Box	Ental
		= -	146	Direct	~		i etai

3 Removal from State

Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.

	Live Birth 2 Fetal death	3 Ectopic pregi
1 🔲	Pregnant at time of death	5 Other (specify
3	Unknown	

20b. Place of

1 Yes 2 9 Unknown 2 No Part II. Other significant conditions contr

ibuting to death but not	resulting in the	underlying	cause g	given in	Part

25. Was case referred to medical examiner?
1 \(\sum \) Yes 2 \(\sum \) No 27. Manner of Death 1 Natural 5 Pending

1100	spitai.	1	X In	patient	2
	28a.	Da (N	ate of fonth,	injury <i>Day,</i> Y	(ear)

nt 2 🗆	ER/Outpatient	3 🗆 1	DOA	Other:	1 ☐ Nursii
Year)	28b. Time of injury	М		Injury at work? 1 \(\sum \) Yes	2 🗆 No

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Suicide	6 Cou
4 Homicide	dete

Investigation	
Could not be determined	28e. Place of Injury - At hom building, etc. (Specify)

injury	M	work?	2 🗌 No	
ie, farm, stree	t, facto	ory, office		

I	28f. Location (Street and Number or Rural Route Number
ı	City or Town, State)
Į	

only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death	n occurred at the time, date and place, and due to	
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day,
Mars a hill Mh	170077	10/00/0

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

U State

Be Completed by

မ

Certificate:

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10:30 November 2011 Perrotta Virginia I. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Shangri La Assisted Living Ellicott City If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year Hours **Director** 1 □ M 2 🔀 F 010-22-8432 83 Yrs MA 11/19/1927 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location notified at with the Maryland Funeral Director Ellicott City Howard 1 Yes 2 X No MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 9 ms 23a or must be r 21042 2846 Pebble Beach Drive United States death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iteπ ledical Examiner r 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event; the Medical Exami any injury or other traumatic event. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify Specify: Completed 3 ☒ Widowed 4 ☐ Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4 or 5+) Law Firm Receptionist Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Thomas Howard Mary Dwyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
2846 Pebble Beach Drive Ellicott City, MD 21042 19a. Informant's Name/Relationship (Type, Print) Rosemary Kanner - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Hawthorne, NY 11/07/2011 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. . Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. Collins - W 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between 4 years Immediate Cause (Final Ph sician/ Alzheimers Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events resulting in death) Last the burial-tran and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 for use as attending 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month Year 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown ed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by been signer should be c 1 Yes 2X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has blirector, page 2 s autopsy performe death? Yes 2 X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) director, Be Other: 4 \square Nursing Home 5 \square Residence 6X Other (Specify) Living Hospital: 1 Yes 2X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: iniury 1 XNatural 5 Pending 24 hours after death. Funeral Director: A Investigation Accident the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ģ 4 Homicide determined filled in Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

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Registrar
DHMH 17 Rev 06-2011

State

Harry Li

MD

Dark

D56531

Columbia, MD

November 2, 2011

21045

m D

8600 Snowden River Parkway #301

aistrar's Signature

30. Name and address of person who completed seuse of death (Item 23a) (Type, Print)

	1 - State Registrar Amend 19a. 1. Decedent's Name (First, Middle,	Last)				,ato or L		2. Date of De		2U1 Year	3. Time of	Death	
an/ cal	CHARL		IFFORD	PRES	SLEY			OCTOBER			7:58	P M	
ner	4a. Facility Name (If not institution, 3704 Mar1brough	-	nd number)			City, Town, or or or or	Location of Death			County of Deat	h George's	s	
Г	5. Social Security Number	6. Sex 1 K M 2		n yrs. last birt	hday) If L	Inder 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Birl (Month, Da	th y, Yea <i>r</i>)	g. Bir Co.	thplace (State or untry)	r Foreign	
	186-52-9387 Usual Residence of Decedent	1		53	Yrs.			April	20 19	9581	PA		
iş	10a. State 10b. County			Dc. City, Town							10d. Inside Cit	ty Limits	
Director	MD Prince	e Geor	ge's Co	ollege		f. Zip Code			10a Citi:	zen of What Co		2 L NO	
Funeral	3704 Marlbrough	Way				20740			-	ted Sta			
	11. Marital Status	Arn	s Decedent Ever				ispanic Origin? (Sp n, Mexican, Puerto		1	14. Race - Ame Black, White			
d by	1 X Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☐ Divorced	If Y	Yes 2 No Yes, Give ar or Dates. —V	POST- TETNAM	1 🗆 Y	es 2 X No	Specify:		5	Specify: Bla			
To Be Completed	15. Deceden (Specify only higher	t's Education	1		Decedent's	Usual Occup	ation during most of wor	kina	16b. Kir	nd of Business	Industry		
	Elementary/Seconday (0-12)	1	llege (1-4 or 5+)	Ma	life. DO NO	T use retired)			Pr	ivate			
	10th Mechanic Private 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)												
	Jesse Pressley Irene Johnson												
	19a. Informant's Name/Relationsh Lydia Timbers/			19b	. Mailing Add	dress (Street a	and Number or Rul	ral Route Numbe College	r, City or Par	Town, State, Zij k , MD 2	p Code) .0740		
	20a. Method of Disposition			20b. Place o	f Disposition	(Name of		Date		cation - City or			
	1 ☐ Burial 2 🕱 Cremation 4 ☐ Donation 5 ☐ Other (S		I_	Riverd Cremat	nrv	T Kther place	11/2	2/2011			Mary1a	ınd	
	21. Signature of Funeral Service Li	icensee			22. Nan		ss of Facility Poro Pike						
_	23a. Part 1. Enter the disease, or	complication	s that caused the	~						Le, FID Z	Approximate	te	
	shock, or heart failure. List o Immediate Cause (Final	nly one cause	e on each line.								Interval Bet Onset and I		
	disease or condition resulting in death)	a	Due to (or as a co	onsequence	of):								
eľ	Sequentially list conditions,	b. —	Oue to (or as a co			EASE							
xamine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury		EPATITI			OHOL							
ш	that initiated events resulting in death) Last	C	Due to (or as a co	onsequence	of):								
edica		d											
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If y	es, outcome of p	pregnancy	2 🗆 Est.				23d. Date of delivery				
sicia	in the past 12 months? 1 Yes 2 No	4 [☐ Pregnant at tir ☐ Unknown			er (specify)	БУ			Month	Day	Year	
	9 ☐ Unknown Part II. Other significant conditio	ns contributi	ng to death but r	not resulting	n the underl	ying cause giv	ven in Part I.	23e. Did t	obacco u	se contribute to	o the cause of d	leath?	
ed by								1 🗆	Yes 2	□No 3□F	Probably 4 X	Unknown	
Completed								24a. Was		prior to	utopsy findings a	available cause of	
Com								perfo	ormed?	death?	s 2 No		
Be c	25. Was case referred to medical examiner? 1 X Yes 2 No	Hospital	l:	- 🗆 = 50/0		Oth	ace of Death (Che						
te: To	27. Manner of Death		1 ☐ Inpatient a. Date of injury (Month, Day, Ye	28b.	Time of njury	28c. Injur	y at	lome 5 Resi 28d. Describe I			olfy)		
Certificate:	1 Natural 5 Pendin 2 Accident Investig 3 Suicide 6 Could	ation			M	1 🗆	Yes 2 No						
Cert	4 Homicide determi		Place of Injury building, etc. (S		rm, street, fa	ctory, office		28f. Location (City or Tou		i Number or Ru	ural Route Numb	oer,	
ical	29a. Certifier 1 X Certifying	Physician: T	o the best of my	knowledge,	death occur	ed at the time	, date and place, a	and due to the ca	use(s) an	d manner as st	ated.	annor state	
1 ===	only one) 3 Certifying	Nurse Pract	the basis of examinationer: To the bes	nination and/o	r investigation ledge, death	occurred at th		at the time, date ace, and due to the	ne cause(s) and manner as	s stated.	inner state	
Medical	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo												
Medi	Dali Asa	1 /2	7	1		MD# (038392		OCTO	BER 28,	2011		

Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November TO 2011 0044 Joyce Elaine Potter Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ceci1 214 Hollingsworth Manor **Elkton** If Under 1 Year Months Days 5. Social Security Number If Under 24 Hrs. Hours Min. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 DM 2 X F Months OCT 10. Year 949 Maryland Director 212-52-9539 Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Maryland Ceci1 E1kton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 214 Hollingsworth Manor 21921 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: 3 X Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) In Her Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed h and Mental H 7 is marked of Orville Reeves Anna Spratt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 618 W. Pulaski Highway, Elkton, MD Michele MacKenzie/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Gifpin Manor or other place) Memorial Park November 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Ponation 5 ☐ Other (Specify) Elkton. MD 2011 Hicks Home for Funerals, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility < 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical to (or as a consequend Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 D No
9 Unknown Pregnant at time of death Day 5 Other (specify) signed by the a g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed should 24b. Were autopsy findings available 24a. Was an page 2 s prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific: completed filled in by the funeral director, I of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending Division 1 Yes 2 🗌 No Investigation Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 30. Name and address of pe completed cause of death (Item 23a) (Type, Print) 0 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

			For State Registrar	State of Mary		ertificate of I			giene Reg. No. 2 N	11 36686
Phy	ysicia	n/	1. Decedent's Name (First, Middle, Las	ath 2 Day 20	3. Time of Death					
	Medic kamin	al	Pauline Vita Ran 4a. Facility Name (if not institution, give			4b City Town o	or Location of Deatl	раг 0930 м		
	Xa IIIIII	GI.	Easton Memoria	* , _	1	Eastor			4c. County of 1	
	neral ector		104-03-4230	7. Age (In	yrs. last birthday, 9 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl 01 ^{(M} 27节, Day		Birthplace (State or Foreign Country) PA
and	ta la		Usual Residence of Decedent 10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
Maryl 28a-f	otifie	irect	MD Talbot		Roya1	0ak				1 ☐ Yes 2X No
h with the	nust be n	neral D	10e. Street and Number 25500 Chance Farm	Rd		10f. Zip Code 21662	2		10g. Citizen of Wha	t Country?
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If the 21 is marked other than "natural", or items 23a or 28a-f show	al Examiner	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates.	in U.S. 13	. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🌠 No	an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		American Indian, White, etc. Thite
21215-0036 within 72 hours after giene.	e Medica	omple	15. Decedent's Ed (Specify only highest gra Elementary/Seconday (0-12)	de completed) College (1-4 or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retired)	during most of wor	rking	16b. Kind of Busin	
d 2- ed wit Hygier	ent, th	an I	12 17. Father's Name (First, Middle, Last)		Home	maker	18 Mother's Nar	me (First, Middle, I	Own Hon	ie
/lan d be fil Mental	rtic ev	၉	Frank Vita					ine Brig		
, Maryland od 2 should be filed salth and Mental Hy n 27 is marked oth	er trauma		19a. Informant's Name/Relationship (Ty, Joyce R. Philip	_{pe, Print)} (Daughter		ling Address (Street			; City or Town, State	
Baltimore, permit. Page 1 and Department of Hea	ury or oth		20a. Method of Disposition 1	Removal from State	20b. Place of Disp Chesapea Ce	position (Name of ematory or other pla lke Cremat enter	fion 10-2	Date 7-2011	20c. Location - Cit	
Balt permit. Departi	any inj once,		21. Signat of Form Service I	F France		Pellows	Helfenbe	in & New t Easto	mam Funer on MD 2160	cal Home P.A.
Ph sic	cian/		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	a. Pulma	onary	ter the mode of dyir	-	or respiratory arro	est,	Approximate Interval Between Onset and Death
Exam	niner			Due to (or as a co	nsequence of):					
uted	ansit	ledical Examiner	Sequentially list conditions, if any, leading to immediate cause (Disease or iinjury that initiated events	Due to (or as a co	nsequence of);					
ox 68760 eath certificate be executed attending physician and	ne burial-tı	dical E	resulting in death) Last	Due to (or as a co	nsequence of):					
certifica			LOD: Was doordon program	23c. If yes, outcome of p	regnancy	□ Estable pre-res			23d. Date o	of delivery
s, P.O. Box es that the death c signed by the atten	ached for	Physician/N	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at tim g ☐ Unknown	e of death 5	Other (specify)			Month	Day Year
ords, P.O. requires that the			Part II. Other significant conditions co		^		ven in Part I.	1		te to the cause of death?
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and	page 2 sho	Completed by	AU	7				24a. Was a autop perfor 1 Yes	rmed? prio	e autopsy findings available r to completion of cause of th?
ital sician: certific	sctor,	Be	25. Was case referred to medical examiner? 1 Yes 2 No	lospital:		100	lace of Death (Che	ck only one)		
of V g Phys er this	=	و: <u>1</u> 0	27. Manner of Death	28a. Date of injury	2 ER/Outpati	of 28c. Injur	4 ∐ Nursing ⊦ ry at	1	ence 6 Other (5	Specify)
Sion (Attending death. ctor: Afte	he funer	ficat	12 Natural 5 Pending 2 Accident Investigation	(Month, Day, Ye	ar) injury	work	ḱ?] Yes 2 □ No		,,	
Divisi ital or Att urs after d	lled in by t	al Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (Sp		treet, factory, office		28f. Location (S City or Tow.		r Rural Route Number,
Division To the Hospital or Attent within 24 hours after deatl To the Funeral Director.	прleted fii	Medical	(Check 2 Medical Examir only one) 3 Certifying Nurse	ician: To the best of my liner: On the basis of examile Practioner: To the best	nation and/or inve	stigation, in my opini	on, death occurred	at the time, date at	nd place, and due to	the cause(s) and manner stated.
P § § ₽	Ō			idyanath			5 77 L		29d. Date signed (NOCHOR)	10nth, Day, Year) 26 20 11
_6			30. Name and address of person who co Lakshmi Vaidyanat	han 219 S	. Washir		Easton M	1D 21601		
Re	State gistra	-	31. Date filed (Month, Day, Year) OCT 28 2011	32 Registrar's S	_	. 4.1				
DHMH 17 R			- UO1 40 2011	Keneva	13. 190	2500				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36687 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Eileen A. Rosenfelder 4:46 P. M 2011 <u>October</u> 30. Medical 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Howard Gilchrist Center Columbia If Under 1 Year | If Under 24 Hrs. 8. Date of Birth of b. th, Day, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 🗆 M 2 🔀 F March Director 189-16-9735 1924 Pennsylvania Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits aţ 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland Director notified MD Anne Arundel 1 Yes 2 No Severn ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 1919 Stonecastle Drive 21144 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates. Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White "natural", 3 X Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Homemaker Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ James Golden Anna Howe other traumatic Page 1 and 2 should I ment of Health and Mc 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Joan Ward/Daughter 1919 Stonecastle Drive, Severn, MD 21144 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Geo. Wash. University Medical Center October 30 1 🗌 Burial 2 🗆 Cremation 3 🗆 Removal from State Washington, D.C. 4 Donation 5 Other (Specify) 2011 22. Name and Address of Facility Columbia Mortuary Services, P.A. 21. Signature of Funeral Service Sta 9013 Annapolis Road, Lanham,MD 20706 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Complication Months disease or condition Medical resulting in death) Due to (as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or iinjury that initiated events -tran and Due to (or as a consequence of): resulting in death) Last burial attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ĮQ. Month Day Year the 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dysarthria 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? fibrillation 24a. Was an has page 2 autopsy performed this certificate 1 ☐ Yes 2. ☐ No Yes 2 Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Specify) Hospice ဂ္ဂ ER/Outpatient 3 DOA 1 Inpatient 2 I To the nuse... within 24 hours after deau...

To the Funeral Director, After th 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 11🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year, D0060634 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

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gistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State 36688 Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month October 20,2011 1647 Linda A. Robinson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2110 Alice Avenue Oxon Hill Prince Georges Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 F Days Hours 215-54-6725 Wash. DC Director 60 June Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD PG Oxon Hill . JO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2110 Alice Avenue 20745 United States items death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. 1 Never Married 2 Married "natural", or þ 72 hours after Maryland 21215-0036 1 Yes 2 No Specify Specify: Completed 3 Widowed 4 X Divorced Black Year or Dates the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry a. Decedents of solid Occupation (Give kind of work done during most of working life. DO NOT use retired) 'orensic Psychiatric Counselor (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) St. Elizabeth Hosp. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ other traumatic Alberta Diggs Saunders George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1115 Stevens Road, SE
Washington, DC 20020 19a. Informant's Name/Relationship (Type, Print) Cassandra Monroe/daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/29711 cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🔲 Removal from State njury or Washington Nat. Cemetery Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) & 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hodges Edwards F.H. Suitland, MD. 20746 3910 Silver Hill Rd., 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Cardiopulmonary Arrest disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Chronic Obstructive Pulmonary Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) that the death certificate be executed Congestive Heart Failure sician and burial-trans Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Human Immunodeficiency Virus Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 Yes 2 No certificate Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examinera 1 Ves 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 Inpatient 2 I ER/Outpatient 3 I DOA s after death.

I Director: After this of in by the funeral di 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation 6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours af

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) MD3340 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

Ave, se, Washington, DC

1310 Southern

3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MED#26, 29a, 29 open D11/9/11; BWM CCC ertificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Oct. 201 T 18 Shepherd 2017 Lester Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Adventist Hospital Montgomery Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F 5/15/1932 Country) 79 Director 558-40-5389 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits death with the Maryland Examiner must be notified at Director 1 Yes 2 □ No MD Montgomery Silver Spring 10f. Zip Code 10e. Street and Numbe ö 10g. Citizen of What Country? 23a Funeral 214 Ġeneva Āvenue 20910 items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 195

If Yes, Give 1 0 13. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0. 2 □ No 1950 ģ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural", 3 Divorced 4 Divorced 1954 Completed Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Housing marked other than Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Private Industry Training And Education Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) Louis Shepherd Edna Cosse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 je 1 and 2 si t of Health a If item 27 i Geneva Ave. Ave. Silver Spring, MD 20910 <u>Gloria G. Shepherd/Wife</u> Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite any injury or ot ☐ Burial 2X Cremation 3 ☐ Removal from State 10/28/11 Chesapeake Beltsville, MD 4 Donation 5 Other (Spec fy) 21. Signature of Funeral Service 22. Name and Address of Facilitatney's Funeral Home, Inc. cc0278 Georgia Ave. NW Washington. 3831 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical sequence of Due: (or as a o Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine The law requires that the death certificate be executed n and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the bur Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 No ed by the a 9 Unknown 9 Unknown Part II<mark>. Other significant conditions</mark> contributing to death but not resulting in the underlying cause/give signed I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate within 24 hours after cleath.

To the Funeral Director: After this certificate completed filled in by the funeral director, page Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 R 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 \sum Yes 2 \sum No Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one 70244 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 7600 CARROLL

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30. Name and address of person who completed cause of death (Item 23a) (Type

31. Date filed (Month, Day, Year)

NOV 0 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 1846 26. Keith Douglass Shearer October 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Montgomery Silver Spring Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Months Hours Min 210-12-4109 **Director** 1 🗶 M 2 🗆 F 84 Yrs June 30, 1927 Pennsylvania Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location at 10a. State Director ms 23a or 28a-f s must be notified 1 Yes 2 No Silver Spring Prince George's Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3148 Gracefield Road, #216 20904 U.S.A. death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Examiner Armed Forces?

1 XI Yes 2 \(\subseteq \text{No} \) 1945 Black, White, etc. 0 by 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 📜 No Specify: "natural" 3 Widowed 4 Divorced 1949 White Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) the Higher Education Counselor 5+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Margaret Robinson Samuel Wilson Shearer 1 and 2 should be of Health and Meritem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2714 Owens Road, Brookeville, Maryland 20833 Robert G. Keller-Personal Rep. other Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Department of Important: If it any injury or o Burial 2 ☐ Cremation 3
 Removal from State cemetery, crematory or other place 10/31/2011 Lewistown, Pennsylvania Donation 5 Other (Specify) ind Memorial Cem. 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. erva 11800 New Hampshire Ave., Silver Spring, MD 20904 Part L Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cholangitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine the burial-transit Cause (Disease or injury that initiated events Biliary Cancer and Due to (or as a consequence of resulting in death) Last attending physician Physician/Medical P.O. Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Day the g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 1 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe has death?
1 Yes 2 No 1 Yes 2 X No Division of Vital of or Attending Physician:

after death.

Director: After this certifications 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify 1 ☐ Yes 2 🗓 No မ 1 X Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 \square Pending 1 Yes 2 No Accident Investigation filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Hospital Medical 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of ertifie 29c. License number 29d. Date signed (Month, Day, Year) 8+1 October 26, 2011 D0063343 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Irina Yuryevna Ruban,

NOV 0 1 2011

M.D.,

1500 Forest Glen Road, Silver Spring,

Maryland 20910

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.

AMEND ITEM#6perFH, G922, 127, 2872011, WS
State of Maryland / Department of Health and Mental Hygiene

		'	1 - State Registrar Certificate of Death Reg. No. 201											
п	Physicia	an/	1. Decedent's Name (First, Middle, Last) 2. Date of Death Claire S. Sanford Ctober 30, 2									eath		
	Medi	cal	Claire S. S 4a. Facility Name (if not institution	Sanford		4b. City, Town, or	1 1 1 D				9:45	ам		
	Examir	ner	14705 Pony Past	ure Place		Silve	r Sprin	g	4c. County of Death Montgomery					
	Funeral Director		5. Social Security Number 577–30–8456	6. Sex 7. Age (In yrs. 83	. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	in. Dec.	14, Year) 92	9. Birthplace (Start) 9. 1927				
	nd how at	=	Usual Residence of Decedent 10a. State 10b. County		10d. Inside City Limits									
	faryla 3a-f s iified	Director	MD	Montgomery	Silve	r Spring					1 ☐ Yes 2	2 X No		
	or 28									10g. Citizen of What Country				
	s 23a	era	14705 Pony Pasture Place 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-								SA			
	death item ner m		11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? in, Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	14	. Race - Ameri Black, White,		!		
Maryland 21215-0036	urs after ural", or Il Exami	ted by	1 Never Married 2 🔀 Mar 3 Widowed 4 Divorced	If You Cive		1 ☐ Yes 2 🛂 No	Specify:		Sp		nite			
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lany	should and A is ma auma		19a. Informant's Name/Relations	nip (Type, Print)	19b. Maili	ng Address (Street	and Number or	Rural Route Nur	nber, City or To	wn, State, Zip	Code)			
	ind 2 ealth m 27 her tr		Lewis R. Sanfo			5 Pony Pa	asture 1					06		
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S	3 Removal from State	cemetery, crei	osition (Name of matory or other place tan Crema	tory No	Date 0v. 1 2011	1	ation - City or Texandri				
Balt	permit. Depart Import any inj once,		21. Signature of Funeral Service L	icensee	5	Francis J OO Univer	ss of Eacility Sity Bl	ns Fune	ral Hom Silver	ne Inc. Sprin	g, MD 2	0901		
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused the de							Approximate Interval Between			
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68760	tificat ng ph as th	₩	IF FEMALE:											
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P.O.	that the	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
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ecor!	Physician: The law rethis certificate has be ral director, page 2 sho	Completed by						р	/as an utopsy erformed? ⁄es 2 ☑ No	prior to c death?	opsy findings av ompletion of car 2 No			
alF	ian: T	BeC	25. Was case referred to medical examiner?			26. P	lace of Death (C		es zezivoj	1 103	2 (3)110			
Σ	hysic his ce I direc	P	1 Yes 2 No	Hospital: 1 Inpatient 2			er: 4 🗌 Nursi <u>n</u>	g Home 5 🖺 F	esidence 6	Other (Speci	fy)			
on of	nding Path. r: After tlee funera	Certificate:	27. Manner of Death 1 Natural 5 □ Pendir 2 □ Accident □ Investi		28b. Time o injury	work		28d. Descri	oe how injury o	occurred				
Division of Vital Records, P.O.	al or Atte s after de l Directo d in by th		3 Suicide 6 Could 4 Homicide determ			reet, factory, office			on (Street and Number or Rural Route Number, Town, State)					
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial the state of the complete of the complete of the contraction	Medical	(Check 2 Medical E	Physician: To the best of my kno examiner: On the basis of examinat Nurse Practioner: To the best of	ion and/or inves	stigation, in my opini	on, death occurr	ed at the time, da	ate and place, a	nd due to the c	ause(s) and man	iner stated.		
	To th withir To th	2	29b. Signature and title of certifier		VO	29c. Licens D371	e number	,	29d. Date	signed (Month	, Day, Year)			
	3		30. Name and address of person	who completed cause of death (Ite	em 23a) (Tyne						-			
			G. Coleman, MD	1355 Piccard			Le, MD 2	20850						
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature facts	1.								

For State Registrar

10a. State

Director

Funeral

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Completed

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IF FEMALE

examiner?

1 🗌 Yes

(Check only one)

29b. Signature and title of certifier

isa M. Shah

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) October 20 l° l 0822 A M 30 Steven A. Sanborn 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery Shady Grove Adventist Hospital Rockville 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Jan 13, If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours Washington, DC Jan. 58 215-62-7371 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 Yes 2 No Derwood Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20855 7253 Millcrest Terrace Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ■ No Black, White, etc 1 Never Married 2 Married 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry College (1-4 or 5+) Elementary/Seconday (0-12) Photography Photographer 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Barbara A. Avery Thornton V. Sanborn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8922 Barrowgate Court, Potomac, Maryland 20854 Phillip H. Ligon, Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metropolitan
Crematorium. Inc. 1 Burial 2 Cremation 3 Removal from State Nov.1,2011 | Alexandria, Virginia 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Molesworth-Williams, P.A., Funeral Home
26401 Ridge Road, Damascus, Maryland 20872 al Service 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Respirator disease or condition resulting in death) Due to (or as a consequence of rena Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a consequence of ostridi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): es, outcome of pregnancy

Live Birth 2
Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 👗 No ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 28a. Date of injury (Month, Day, Year) Manner of Death 28c. Injury at work?
1 Yes 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending 2 🗌 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide determined

Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed þ Completed To the Funeral Director: After this certific completed filled in by the funeral director, Be Certificate: To within 24 hours after deatl Medical

> State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year) NOV 0 1

medical 9901 mo

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

69908

29d. Date signed (Month, Day, Year)

MD 20850

Rockville

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar 36693 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ,2011^{Year} Physician/ PEEHWA CHU SUN Month OCTOBER 2:10P Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
Dec. 5, 1919 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 273-80-6054 1 □ M 2XXXF Days Hours 91 China Country) Director Yrs. Dec. Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified Frederick Frederick Maryland 28a-f 1 🗌 Yes 💥 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 1033 Chinaberry Drive 21703 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner ō þ 1 Never Married 2 Married Yes 2 X No 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Chinese "natural", Specify. Completed **¾X**Widowed 4 □ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO_NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own home other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental F 27 is marked of traumatic ever ഉ Chu Su-Yuan Shiu-yin Sun 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other transcores 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alexander Sun - Son 116 Mountain Creek Circle, Frederick, Maryland 21702 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 😾 Cremation 3 🗀 Removal from State 11-1-2011 Stauffer Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland Canu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ failure rena disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** leural ettusion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exam respiratory tailure burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death Month Day Year 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 ☑ No 2 🗌 No 1 Tes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes Other: ပ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 24 hours after death. 1 Natural 5 Pending 24 hours after death. Funeral Director; Ai 2 Accident
3 Suicide
4 Homicide 1 🗌 Yes 2 🗌 No Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier no D71319 OCTOBER 29 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 MO L'ARGL WALDMANN State

DHMH 17 Rev 7/2009

Registrar

P.O. I

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36694 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Month Physician/ 70/53/5077 <u>6:40</u> A ^M James William Saunders Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Mandrin House Harwood 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 06/01/1941 1 🛛 M 2 🗆 F Months Hours 216-38-2495 70 Director Usual Residence of Decedent 28a-f shov 10d, Inside City Limits 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State death with the Maryland Director 1 X Yes 2 No Prince Georges Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 12607 Pleasant Prospect Rd. 20721 AZU Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 No Specify. If Yes, Give Year or Dates Specify: **Black** Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 0wner <u>Automotive</u> Department of Health and Mental Hygic Important: If item 27 is marked other any injury or other traumatic event, If once. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Page 1 and 2 should be ment of Health and Menta Denver Harrison Saunders Estelle Rucker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u> 12607 Pleasant Prospect Rd., Bowie, MD 20721</u> Mary E. Saunders / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State t. Lincoln Cemetery 11/04/2011 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) Strickland Funeral Services 22. Name and Address of Facility Signal of Funeral Sen 6500 Allentown Rd., Camp Springs, MD 20748 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Cell Malignant Lymphoma disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence oi). ir any, leading to immediate cause. Enter Underlying executed Cause (Disease or linjury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Fctopic pregnancy signed by the atter in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Other (specify) g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 1 Tes 2 No 3 Probably 4 M Unknown Division of Vital Records, Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy has performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be director examiner? Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Mandrin House 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred s after death.

I Director: After the in by the funeral Certificate: injury 1 X Natural 5 Pending Accident 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinior, logath occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 24 To the F 3 [only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 70/37/5077 D23743 30. Name and address of person who completed cause of death (Item 28a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Martin D. Weltz Mar. Date filed (Month, Day, NNV 0 3

NOA 0

7525 Greenway

32. Registrar's signatu

ťt Dr∙₁ Greenbelt₁ MD 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar 1 Decedent's Name (First Middle, Last) 2. Date of Death Day Month Physician/ 7:55 A M William Stephenson 2011 10/Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death Examiner 5605 South Marwood Blvd. Marlboro <u>Prince George's</u> Upper Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 XM 2 □ F Days Hours Min. (Month, Day, 225-58-4062 66 NansemondCty. Director 1945 Va May Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" any injury or other traumatic events. 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Suitland 1 X Yes 2 No Prince Georges Maryland | 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 20746 Funeral 2320 Lakewood Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?

1 1 Yes 2 1 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 X Never Married 2 Married Specify: Black If Yes, Give Year or Dates 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) General Service Administration Government 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Thomas B. Stephenson Lula Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lula V. Stephenson / Mother 2320 Lakewood St. Suitland, Md. 20746 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Washington National 11/2/2011 Suitland, Md. 4 Donation 5 Other (Specify) Signature of Funeral Service Licer 22. Name and Address of Facility
Alexander S. Pope.
5538 Mariboro Pike/ Forestville, Md. 20747 Part 1. Eigher the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ on Carel 0 disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year 5 Other (specify) Pregnant at time of death ate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed ours after death.

eral Director: After this certificate I filled in by the funeral director, page Yes 2 XNo 25. Was case referred to medical B 26. Place of Death (Check only one) Hospice Other: 1 Yes 2**X** No 4 Nursing Home 5 Residence 6 K Other (Specify) Sister Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🛚 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 only one) 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year,

State Registrar

NOV 0

Michael Pishvaian 3800 Reservoir Road, NW, Washington, DC 20007

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Vovember Janice Messick Sanders Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Memoria aston aIIf Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) If Unde **Funeral** Days Min (Month, Day, Year) Country) Director 28-7832 1 □ M 2 🗶 F 65 1946 Delaware 25, permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 No Caroline Preston 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral United States 3843 Poplar Neck Rd. 21655 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married 1 Yes 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced white Year or Dates Baltimore, Maryland 21215-00 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Clerical Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Norma Thawley Milton Messick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Sanders/Spouse 3843 Poplar Neck Rd., Preston, MD 21655 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗆 Burial 2 💢 Cremation 3 🗆 Removal from State Nov. 3,2011 Cambridge, MD 4 Donation 5 Other (Specify) MidShore Crem. Ctr. Signature of Euperal Service Licensee 22. Name and Address of Facility Framptom Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final st. Federalsburg, MD 21632 Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or a consequence of): Examiner Sequentially list conditions, it any, leading to many class cause. Enter Underlying Examiner Due to for as a consequence of Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury signed by the attending physician and dbe detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 I Inknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? 1 Yes 2 No certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 0 1 Tes 2 No 1 Depatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death.

Funeral Director: After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending iniury Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗮 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 To the F only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

156

Washington St

219 S.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DeShields,

Dennis M.

NOV 08

31. Date filed (Month, Day, Year)

005

Easton, MD 21601

201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HAROLD EDWARD TAYLOR JULY 25. Medical 3:45 P 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 11430 LYNCH ROAD WORTON KENT Funeral 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 XM 2 □ F Months Hours Month, Day, Ye **Director** 218-09-0804 VIRGINIA 90 192 Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a, State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD KENT WORTON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 11430 LYNCH ROAD 21678 UNITED STATES 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Examiner 14. Race - American Indian, Armed Forces?

1 XYes 2 No ō 1 Never Married 2 Married Black, White, etc. þ Maryland 21215-0036 nan "natural", o 1 ☐ Yes 2 XNo Specify: 3X Widowed 4 ☐ Divorced If Yes, Give Completed Specify: Year or Dates WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the should be filed with and Mental Hygier is marked other t 8 FOOD PRODUCTION MAINTENANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or cut. ပ JACOB HUBERT TAYLOR SARA E. ALESHIRE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOBBY BRAMBLE / GRANDSON 113 MALONE AVENUE CHESTERTOWN, MARYLAND 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CHESTER CEMETERY 07/29/2011 CHESTERTOWN, MARYLAND 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND HOME, 21620 Keel 23a. Part 1. Enter the disease or come ications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on ach line Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): that the death certificate be executed burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: for use 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year 2 No detached g Unknown signed by Part II. Other significant conditions contributing to 23e. Did tobacco use contribute to the cause of death? ģ pe or Attending Physician: The law requires Completed 2 should 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy perform page Yes 25. Was case referred to medical examiner? To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital 2 XNO ပ 1 Yes Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death After t Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending (Month, Day, Year) 2 Accident
3 Suicide
4 Homicide Investigation 1 Yes 2 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) To the Hospital of within 24 hours at within 24 hours Medical 10 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause. 29a. Certifier (Check amination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To th only one best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date sigged (Month, Day, Year) D0060301 2

DHMH 17 Rev 7/2009

State Registrar WICHTER

31. Date filed (Month, Day,

128 SKER HO STES LITESTENTOWN, MY

completed cause of death (Item 23a) (Type

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra 36698 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Thompson Jr. Earl Physician/ Roscoe Oct . 25, 2011 Year 8:55a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery 1010 Somerset Lane Silver Spring 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Hours 5/937/1932 79 Georgia 253-44-8420 Director 1 🗚 2 🗆 F Usual Residence of Decedent 10c. City, Town or Location
Silver Spring 10d. Inside City Limits the Maryland Director notified. MD Montgomery 1 Yes 2 No 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? č must be Funeral 23a 1010 Somerset Lane 20904 USA death v 12. Was Decedent Ever in U.S. Armed Forces? 1951 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, ral", or iter Examiner Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1955 Black 1 ☐ Yes 2 ☐ XNo Specify: 'natural", If Yes, Give 3 Divorced Year or Dates th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical I Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Mathematician Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Roscoe Earl Thompson Sr. Mary Murden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 1010 Somerset Lane Silver Spring, Md 20904 f Health Patricia Thompson/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot once. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place. Md. Veteran's Cem. 11/3/2011 Cheltenham, Md 4 Donation 5 Other (Specify) 21. Signature of Puneral Service License PHITTIP AD RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part 1. Enter de disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on ea Immediate Cause (Final Ph sician/ disease or condition resulting in death) 0 Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a nonsequence of): cause. Enter Underlying Tight and the state of the stat Cause (Disease or injury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death Dav Year been signed by the s should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law r within 24 hours after death. To the Funeral Director; After this certificate has b this certificate has performed? Yes 2 No 2 No 1 Yes mpletely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: ပ္ 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred XNatural 5 Pending Accident Investigation М Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 1🗶 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 To the F only one) 🗆 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title-of certifier 29c. License number 29d. Date signed (Month, Day, Year) Oct.27,2011

State Registrar

Ane

30. Name and address of person who completed cause of

Eveline

MD

(Item 23a) (Type, Print)

7500 Hanover Parkway #101A Greenbelt, Md 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 10:55 P.M 2011 October Ennik Telimian Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Village Montgomery Montgomery Village Health Care Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🛣 Months Days Hours April 18 Iran Director 218-21-5735 Usual Residence of Deceden 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked out than "natural", or items 23a or 28a-f sho any injury or orbite tranmatic event, the Medical Examiner must be notified at any injury or pother traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location Director 1 Yes 2 K No Montgomery Village <u>Marylan</u>d Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral Iran 20886 20439 Aspenwood Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Home 12 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Khodabakhshian Shushan Zohrab Telimian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20445 Aspenwood Lane, Montgomery Village,MD. 20886 <u>Simbat Movsessian/Son</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Souls Cemetery 10/28/2011 Germantown, Maryland 4 Donation 5 Other (Specify) A11 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service Li any it East Deer Park Dr., Gaithersburg, MD. 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Diseaseem *vsician/ astern Cormary disease or condition resulting in death) ledical Due to (or as a consequence of): ∡aminer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bundataristic. attending physician and I for use as the burial-transit Exam Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Year Other (specify) Pregnant at time of death Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 1 Natural 28d. Describe how injury occurred injury 5 \square Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0065301 10/25 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19745 Executive Park Circle, Germantown, Maryland 20874 M.D. Farzana Ajmal, 31. Date filed (Month, Day, Year) Registrar's Sign State NOV 01 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36700 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 6:08 PM Physician/ 201 Carnell Thompson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges Doctors Community Hospital Lanham Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X**M 2 □ F Days Hours Min. (Month, Day, Year Yrs Director NC 241-40-6082 81 30 1930 Jan. Usual Residence of Decedent or 28a-f show notified at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 XYes 2 No DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō items 23a or ner must be r Funeral 1507 S St., SE United States 20020 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status "natural", or iten edical Examiner r Armed Force Black, White, etc. ò 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 Yes If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 □ Divorced Black the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "n. any injury or other traumatic event, the Madric once. (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u>Auto Mechanic</u> Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 William Thompson Mary Kornegay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pike Street #E101 400 Pike Wilson, N 20b. Place of Disposition (Name of Vernell Smith/Daughter 20a. Method of Disposition 11/5/11 cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington Nat. Cémetery Suitland, MD 22. Name and Address of Facility Hodges & Edwards F.H. 21. Sign tu of Funeral Service Licensee 3910 Silver Hill Rd., Suitland, MD. 20746 Par 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Sepsis Immediate Cause (Final Physician/ 3 Weeks disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Imonth neumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in death) Last ne Exami The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year signed by the a Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Chronic Obstructive Pulmonary dise 1 XYes 2 No 3 Probably 4 Unknown Completed Chronic kidney Disease 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ເ∧No 24a. Was an autopsy page 2 1 Yes 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: injury 1XNatural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State Registrar

31. Date filed (Month, Day, 3 2011 NOV O

29b. Signature and title of certifie

30. Name and address of person Fredisia

completed cause of death (Item 23a) (Type, Print) SMD 10801 Hickory Ridge Road Suite 215 Columbia, MO 21044 Prancis MD 10801

aneus L

29c. License number

D0061661

29d. Date signed (Month, Day, Year)

Uctober 30, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 N For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death P^{M} **Physician** 23 4:20 Allen Stoney Tate Oct. 2011 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Queen Anne Hospice of Queen Anne Centreville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours 1 ☑ M 2 □ F 19, 1941 Alabama Director 70 420-56-1884 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Evanting runst be notified at once. 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 1 ☐ Yes 21 No Director Maryland Talbot Oueen Anne 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13386 Cannery Road 21657 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 **N**o 1 ☐ Yes 2 ☐ No Specify: Black <u>≥</u> 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Food Processing Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Unknown Lakie Lee Nolen ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21657 19a. Informant's Name/Relationship (Type. Print) 13386 Cannery Rd., PO Box 164, Carolyn Pritchett Tate/wife Queen Anne, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sandtown Cemetery Nov. 5,2011 Hillsboro, Maryland 22. Name and Address of Facility Fleegle and Helfenbein Funeral 21. Signature of Funeral Service Licenses Z Home, P.A., PO Box 160, Greensboro, Maryland2163 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANCER 14 years **Physician** UNG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and sician and burial-trans Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Š 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐Yes 2 ☐ No Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated. within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D3988 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. David Smith, 8221 Teal Dr., Suite 302, Easton, Maryland 31. Date filed (Month, Day, Year, 32. Registrar's Signature State OCT 2 6 201 Registrar

ORIGINAL

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DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36702 1 - State Registra Certificate of Death 2. Date of Death dent's Name (First, Middle, Last, Nov 8, Physician/ 2011 9:45 AMM NOIS SR. Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland 609 Sedgwick Street 9. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8 Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min 1 🖳 M 2 🗆 F Hours Apr 2 1931 Yrs. **Director** 220-26-9256 80 Usual Residence of Deceden f show 10a. State 10b. Count 10c. City, Town or Location 10d. Inside City Limits be notified at Director Cumberland MD Allegany 1 X Yes 2 No or 28a-f 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 23a USA 21502 Examiner must 609 Sedgwick Street or items be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces?
1

Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: white "natural", Korea 3 Divorced 4 Divorced Completed Year or Dates traumatic event, the Medical 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Railroad 12 signal maintenance dept. Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Mental ပ marked Helen Newnam Salvatore E. Crawford and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 9645 Woodland Road New Market ິທີ່D 21774 9645 Woodland Road Michael Thom son item 27 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Kremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A 11/10/20 MD Cresaptown Donation 5 Other (Specify) signature 22. Name and Address fif Furneral Home, PA f Funeral Service L 108 Virginia Avenue: Cumberland, MD 21502 ter the disease, or complications the clused the death to not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part 1. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate AT Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be P.O. Box 68760 as IF FEMALE: nse 23b. Was decedent pregnant 23d Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Po 5 Other (specify) Pregnant at time of death be detached the Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗆 Yes Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy this certificate has death? 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to nedical 26. Place of Death (Check only one) Be examiner? Hospital 1 🔲 Yes 2 No ည ER/Outpatient 3 DOA 1 Inpatient 2 completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death. To the Funeral Director: After Natura 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined To the Hospital Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) itle of certifier 29b. Signatu

Registrar

DHMH 17 Rev 7/2009

State

6-201

Ste. 309 Cumberland, MD 21502

person who completed suise of death (Item 23a) (Type, Print)

625 Kent Ave.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 36703 State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 10/27/201 Physician/ WILLIAM JAMES WILSON, I 1612 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1**X** M 2 □ F DC (Country) 0971871952 **Director** 577-72-4884 59 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 X Yes 2 No Gaithersburg MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 20877 400 W. Deer Park Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2X No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates Specify: Black 3 Ulidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Ikon Office Solutions 12th Facilities Maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Clincyle Law James E. Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trains 400 W. Deer Park Road, Gaithersburg, MD 20877 Traci L. Wilson/wife 20b. Place of Disposition (Name of cemetery) crematory or other place)
Gate of Heaven Cem. 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donardon 5 ☐ Other (Specify) 11/05/2011 Silver Spring, MD 22. Name and Address of Facility Snowden Funeral Home 21. Signatur of Funeral Service Lice enge 246 N. Washington St. Rockville, MD 20850 23a. Part 1. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Cardiac arr disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner pirator Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Recurring that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No 2 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at work? 1 □ Yes 2 □ No 1 Natural iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and signed by the attending physician and do be detached for use as the burial transit Division of Vital Records, P.O. Box 68760

with the Maryland

death

and Mental Hygiene.

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Page 1 and 2 should ment of Health and Me

Maryland

Baltimore.

30. Name and address of person who completed State

Juanita 31. Date filed (Month, Day, Year) NOV 0 1 2011

3 🗌

(Check

only one) 29b. Signature and title of certifier

> use of death (Item 23a) (Type, Print) 9901 medical Ctr Dr. Smith MID

22. Registrar's Signature

Registrar

MD

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D0064413

29d. Date signed (Month, Day, Year)

Rockville MD 20850

2011

October 29

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Baltimore,	permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau		21. Signatur f	4		man (in Di	2. Name and Ad ellows, 200 S. H	dress of Fa	enbei	n & New	nam on l	Fune:	ral 601	Home 1	P.A.	
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68760	ficate g phys	Medi			d												
Box 68	Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death certificate be 34 hours after death certificate has been signed by the attending physiciated filled in by the funeral director, page 2 should be detached for use as the but the but the funeral director, page 2 should be detached for use as the but the but the funeral director.	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2 Unknown	months? No		Birth 2 Fignant at time of	etal death 3	☐ Ectopic pregnancy ☐ Other (specify)					23d. Date of delivery Month Day Year				
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	Sta Registr	te ar	31. Date filed (Monti	OCT 3	1. 2011	gistrar's Sign	A. 4	faces									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 36705 For State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ october 29,2011 12:23PM T. Woodall Brian Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Prince Georges Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number **Funeral** Months Director 579-70-3240 1 **X** M 2 □ F Feb.23,1956 Wash.,DC 55 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County death with the Maryland must be notified at Director 1 X Yes 2 No Suitland MD PG 10g. Citizen of What Country? 10f. Zip Code ò 10e, Street and Number 23a Funeral 20746 United States 6015 Ladd Road items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Examiner Armed Forces Black, White, etc. ö 1X Never Married 2 Married XYes þ 2 🗌 No Page 1 and 2 should be filed within 72 hours after Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black If Yes, Give "natural" Completed 3 Widowed 4 Divorced Year or Dates. al Hygiene. d other than "natura event, the Medical E Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) rchives Specialist National Archives 12 of Health and Mental Hygi litem 27 is marked other other traumatic event, i Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Austin Mary Edward Woodall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
8975 Bridgette Lane
Dentsville, MD 20646 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau Renee Woodall/sister Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 11/9^D/11 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Cheltenham, MD Veterans Cemetery 22. Name and Address of Facility Hodges & Edwards F.H. Funeral Service Licenses 21. Signati Suitland, MD. 20746 Silver Hill Rd., 3910 23a. Part shock ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine attending physician and if for use as the burial-transit reumania Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Pregnant at time of death been signed by the a should be detached i Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 a autopsy performed' Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) filled in by the funeral director, Be examiner? Hospital Other: ၉ 1 Yes ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 5 Pending Natural Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 101 31 ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

State

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 8:47 PMM ^MNov 6, 2011 Westfall Eugene Franklin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Allegany Cumberland WMHS-RMC If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Country 1 🖳 M 2 🗆 F Hours Feb 19 °1934 Director 220-32-4722 Usual Residence of Decedent 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County items 23a or 28a-f sho er must be notified at with the Maryland Director Cumberland Allegany MD 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21502 USA 923 Virginia Avenue within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Race - American Indian Examiner Armed Forces? 0 þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates white "natural" Completed 3 Widowed 4 X Divorced 1953-1955 Medical 15. Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) al Hygiene. life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Jim Garland's Petroleum Truck driver 8 event. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked or Margaret L. Storns ပ Frank F. Westfall other traumatic Page 1 and 2 should tailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 LaFayette Avenue Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trau Glenn Westfall son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 Burial 2 Sremation 3 Removal from State Scarpelli Funeral Home, P.A. MD 11/8/201 Cresaptown ☐ Donation 5 ☐ Other (Specify) eral Service 22. Name and Address In Funteral Home, PA Signature 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Erfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ neunum disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ate has been signed by the atte page 2 should be detached for Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4- Nursing Home 5 Residence 6 Other (Specify) ဨ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident iniury 5 Pending 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) D0033280

State Registrar ent Are. Ste. 101 Cumberland, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrack Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of 2310 Oceth. 26, 2011 Year Physician/ Wajiha Yousif Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Rockville .. County of Death Montgomery **Examiner** Hebrew Home of Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 9 Mants Par 1922 8 Syria 578-50-8240 83 **Director** Usual Residence of Decedent 28a-f shov 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Montgomery Potomac 1 ☐ Yes 2 🕇 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö Funeral 20854 8614 Tuckerman Lane with items 23a USA 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ò þ 1 Never Married 2 X Married _{Specify:}White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give "natural", 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+ Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Maria Aboud 17. Father's Name (First, Middle, Last) Elias Jacoub 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8614 Tuckerman Lane Potomac, Md 20854 Elias H. Yousif/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Speciff) Chesapeake Crem. 10/31/201 Beltsville, Md 5 Other (Speciff) Signatur Xf unefal Sewfice Live PHTTTP MRTNALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd. Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ ementia disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial applied. and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 4 Pregnant 9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in magnif Medical 29a. Certifier

State Registrar (Check

mire

29b. Signature and title of certifier

31. Date filed (*Month, Day, Year)* NOV 0 1 2011

Fazli

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6121

DHMH 17 Rev 7/2009

Montrose

32. Registrar's Signature

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Rockville

29d. Date signed (Month, Day, Year)

10-27-2011

20852

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year Physician/ 5:05PM 2.01 PHILLIP 5. ANDREWS Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Social Security Number 6. Sex **Funeral** 1 XM 2 □ F Director 12/11/1949 215-52-4985 61 show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State must be notified at Director Baltimore 1 X Yes 2 No N/A MD 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 'n 21206 Funeral USA 23a 4814 Strathdale Rd. ral", or items 2 Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced "natural" Year or Dates the Medical 16b. Kind of Business/Industry Union 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than, Baptist Head Start Elementary/Secondary (0-12) College (1-4 or 5+) I Health and Mental Hygrans item 27 is marked other the rother traumatic event, the Maintenance Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Beatrice Smallwood Raymond DeLoatch 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1708 Winford Rd. Baltimore, MD 21239 19a. Informant's Name/Relationship (Type, Print) 1708 Winford Rd. Baltimore, Senora Andrews- Wife 20a Method of Disposition 20b Place of Disposition (Name of Date 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. cemetery, crematory or other place) 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State OwingsMills, MD 11/17/2011 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest March F/H 1101 E. North Ave. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, MD 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Syndrome Physician/ Acute iratory disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Tearn Encephalopa the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last nding physician Completed by Physician/Medical Syndrome (A) Year inodeficiency Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? 1 Live Birth
4 Pregnant a
9 Unknown Month Pregnant at time of death signed by the and ld be detached for 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an ate has bage 2 s performe 1 Yes 1 Yes V No certificate funeral director, **Division of Vital** Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) a No ဂ္ 1 🔲 Yes Inpatient 2 ER/Outpatient 3 DOA this Medical Certificate: 27. Manner of Death Date of injury (Month, Day, Year) 28b. Time of 8c. Injury at 28d. Describe how injury occurred Natural Natural 5 Pending 1 🗌 Yes 2 🗌 No of the state of the state. At the state of t Investigation Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or inventigation in a stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2

To the F

complete only one 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

SINA TIMIL 32 Registrar's Signature

M.D.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL

RES-000

29c. License number

5601 LOCH RAVEN BLVD RALTIMOR

11/06/2011

Registrar

DHMH 17 Rev 06-2011

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 201 Year NOVEMBER 7 05 Ам R. ANGLIN, Sr. ALBERT Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFORD FOREST HILL HEALTH & REHAB CENTER FOREST HILL 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral 1 **X** M 2 □ F Hours Min 11^M02/1922 Virginia Director 89 222-10-4610 Usual Residence of Decede permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 22 - - - - any injury or other traumatic event, the Marie 1 once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Baltimore Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11709 Mohr Road 21087 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 A Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Widowed 4 Divorced WW 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Al's Discount Liquors 12 Self-Employed 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Clara Lenz Francis Anglin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21087 Hazel Anglin (wife) 11709 Mohr Road - Kingsville, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gracelawn Mem.Pk.Cem. 11/17/2011 New Castle, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. 6 9 11750 Belair Road - Kingsville, Maryland 21087 00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition pheneone Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or imjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No P Month Day Year Pregnant at time of death Unknown been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed certificate has 1 ☐ Yes 2 No Yes 2 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident
Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifler 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 03 227 November 201

State

Registrar

DAVID DUNN

31. Date filed (Month, Day, Year)

17

rack

21014

MD

BEL ATR

615 WEST MACPHAIL ROAD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 10b, per fh e921 11-17-11 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month LBERT Day 1559 M Medical 4a. Facility Name (if not institution, give street and number Examiner 4b. City, Town, or Location of Death 4c. County of Death ADVAUTIST HOSPITAL TAKOMA MO MONTGOHERY **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 218-10-97 1 M M 2 D F (Month, Pay, Year) Months Director Usual Residence of Decedent oortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Prince George Page 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location **Funeral Director** 10d. Inside City Limits ADELPHI 1 🗌 Yes 2 🔀 No HOW GOVIE 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? R1665 10100 USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🗓 No 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify If Yes, Give 3 Widowed 4 ☐ Divorced Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) RESEARCH SCIENTIST CHEMICAL ENGINEERING Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JACOB AARON ISRAEL 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 ROBERT AARON / SON 8500 POSTOAK ROAD, POTOMAC, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any Injury or ot 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State ANSHE EMUNAH AITZ CHAIM CONG. 4 Donation 5 Other (Specify) 11/16/2011 BALTIMORE, MD 21. Signature of Funeral Service Licensee, 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician/ Onset and Death LOVU Medical resulting in death) Due to (*r as a consequence of): Examiner VA Cereber Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examine Due to (or as a consequence of): To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year g | Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Yes 2 No 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) 은 Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death Date of injury 28b. Time of within 24 hours after death. To the Funeral Director: After 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accider (Month, Day, Year) 5 Pending Accident Suicide Investigation 2 🗌 No 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Shaharb 72441 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LYLLA SHAHAB WAS WASHINGTON ADVENTIST HOSPITAL 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month DV Year 2011 Physician/ 17:41 A Bloom Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs.
Months Davs Hours Min. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🛛 F (Month Day, Maryland 67 Director 218-40-0818 Usual Residence of Decedent show 10d. Inside City Limits or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 □ No MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō items 23a or ner must be n 21201 Funeral 509 E. 41st St. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Examiner Armed Force ??

1 Yes 2 No 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. ō þ Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify: "natural", Completed 3 Divorced 4 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation unk (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anna Pearl Williams Clay Jordan Bloom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 509 E. 41st St; Baltimore, MD 21218 Carl Barton - friend 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 🕅 Other (Specify) in state uneral Service Lice 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Severe SEDSIS WEEKS disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** fungemia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury bacteremia burial-trans and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☒ No Month Day 5 Other (specify) Pregnant at time of death 4 Pregnant : 9 Unknown be detached the ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available 24a. Was an autopsy performed? Yes 2 X No prior to completion of cause of death? this certificate has page 2 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ၉ 2 🗆 No 1 Npatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? injury 1 🗵 Natural 5 \square Pending 2 🗌 No Accident Investigation 24 hours after deatl Funeral Director. completed filled in by the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 within 2 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 19735 NOV 7 2011 Resident physician Lobert MD

State Registrar Emilie

DHMH 17 Rev 7/2009

22 South Greene St. Baltimore MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cobert

Please Type or Print in Black Indelible Ink Freye All Copies Frey Legible. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 201 Jean Physician/ 8 ay November 2:55 РМ Bobby Boykins Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Washington Adventist Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days North Carolina 1 X M 2 □ F Director 241-56-2204 72 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amortant or other traumatic event, the Medical Examiner must be notified at anone. 10c. City, Town or Location unk 10a. State 10b. County Director unk 🗆 Yes 2 👯 Prince George's Landover 10f. Zip Code -unk 10e, Street and Number unk 10g. Citizen of What Country? Funeral USA 20785 2424 Vermont **Avenue** Apt 101 12. Was Decedent Ever in U.S.UNK
Armed Forces?

13. Was Decedent of Hispanic Origin? (Specify Yes or NoIf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status unk Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes 2 ☐ No Yes, Give Baltimore, Maryland 21215-0036 black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation un 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) unk unk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk မ Barnes Lela Boykins June 19b. M2424d Vermont Naveor Rapel Olymber, Tiandover, ZyMdie 20785 19a. Inferenant's Name Relationship (Types Prist) GIOFIA BIAWIEY FILEND Rita Kenney – niece 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 \square Burial 2 \square Cremation 3 \square Removal from State 4 \square Donation 5 X Other (Specify) in state uneral Service Livens 22. Name and Address of Facility State Anatomy Roard 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 655 W. Baltimore St; Baltimore, MD 21201 Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Examiner Seduentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury and burial-tran that initiated events resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Por Month Year Pregnant at time of death 9 Unknown been signed by the should be detached 9 | Linknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy perform 1 🗌 Yes 2 🗌 No Yes 2 No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Manpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျှ . Manner of Death 1 Vatural 2 Accident Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate; After . 5 Pending 1 Yes 2 No 24 hours after death. Funeral Director: A Investigation 2 Accident
3 Suicide
4 Homicide filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one) 29b. Signature and title of certifie person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend 1tem 24a per verb 2921 11-17-11 vt
State of Maryland / Department of Health and Mental Hygiene
amend #20a-c&22 Per FH G921
Certificate of Death

Reg. No. 2 1 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician /Medical 0501 James November 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth
(Month, Day, Year)
Feb 16, 1930 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Minnesota 81 Director 473-28-6985 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 No Director MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip-Code 21231 USA 1709 Bank St; #T2 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ∑ Yes 2 □ N6/17/49

If Ves, Give Year or Dates: 9/24/65 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 🏋 No Specify: white 3 Widowed 4 Divorced 9/24/65 Completed the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12 landscaper landscaping 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mentai and Mental Oliver Bell Laura Uhler traumatic 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. Bell - son 714 Corinne Ave SE; Palm Bay, FL 32909 Health a injury or other permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once, 20a. Method of Disposition
1 ☐ Burial Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 3 Removal from State 11/16/2011 **Bayview Crematory** Baltimore, MD 4 Donation 5 Womer (Specify) in state Name and Address of Facility State Anatomy Board 1901 Eastern Lilly&Zeiler, INC Funeral Home 55 W. Baltimore St; Baltimore, MD 2120121231 22. Name and Address of Facility 2120121231 Ave Part 1. En the disease, or complications that caused the shock, or heart failure. List only one cause on each line. cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician Myocardial disease or condition resulting in death) /Medical Dua to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death filled in by the funeral director, page 2 should be detached for in the past 12 months? 3 Ectopic pregnancy Month Day Pregnant at time of death 5 Other (specify) 2 No the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nas autopsy performed? 1 🗌 Yes 2**X** No 1 Tes 2 🗌 No 25. Was case referred to medical examiner?
1 XYes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 2 ER/Outpatient 3 DOA 2 6 Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred within 24 hours after death. (Month, Day Year) 5 Pending Injury 1 🗌 Yes 2 🗆 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 10 November 11, 2011 RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 DAVID MABEY 31. Date filed (Month, Day, State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Vouemb John Luther Brown Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore Good Samaritan Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)
 N C Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 **X** M 2 □ F Months Hours Min. 6/9/1932 N.C. 79 Director 248-48-2078 Usual Residence of Decedent r 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland Director Baltimore 1 X Yes 2 No N/A MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number ms 23a or must be n ō USA 21217 Funeral 2100 Madison Ave. ural", or items ? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

Yes 2 \(\square\$ No Black, White, etc 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 within 72 hours after Black 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 Widowed 4 X Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Sparrows Point Laborer 8th N/A permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Geneive Brown Isaac Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1537 Kennewick Rd. Baltimore, MD 21218 Nanie Fair-Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State 11/15/2011 Crownsville, MD ponation 5 Other (Specify) Crownsville cemt. March F/H 1101 E. North Ave. ignat re of Funeral Service Lice 22. Name and Address of Facility 21202 MD Baltimore, nt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death diate Cause (Final ⟨Physician/ ase or condition sulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed burial-tran physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No for 5 Other (specify) Pregnant at time of death ed by the a detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy page 2 Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှင် 1 Yes Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral. 28b. Time of 27. Manner of Death 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending 2 No 1 Yes Investigation Accident Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar DHMH 17 Rev 7/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mittel Kappath 8813 Woltham

Cash,

Day, Year)

D0069314

Woods

RA

Parterlle MD 21234

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death November 75,2011 Physician/ Agnes Martha Boyce Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Timmium Stella Maris Nursing Home Baltimore 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 Year 6. Sex 7. Age (In vrs. last birthday) Funeral Months 220-24-6292 1 - M 2 X F Days Hours Febonth 5 Pay 1929 Maryland 82 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if flem 27 is marked other than "natural", or items on other traumatic event. the Maryland once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Parkville Baltimore 1 ☐ Yes 2 🛣 No MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21234 Funeral 3400 North Trail Way USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. Completed by 1 Never Married 2 Married white 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) At Home Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Adelbert Shryock Agnes McOuade ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3400 North Trail Way-Parkville, Maryland 21234 19a. Informant's Name/Relationship (Type, Print) David Boyce-son Nov. 18, 2011 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Gardens, of Faith Cemetery Rosedale, Maryland 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) umone Medical Due to (or as a consequence of) Examiner la Mahlemer Sequentially list conditions, Examine Due to for as a consequence of cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi the Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 24 hours after death.

• Funeral Director: After this certificate has been signed by the a leted filled in by the funeral director, page 2 should be detached it 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 ☐ No 3 ☐ Probably 4 Munknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 🗙 No 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 2 No 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 🗌 Inpatient 2 🗀 ER/Outpatient 3 🗍 D0A Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: AGNES 1 🔀 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29d. Date signed (Month, Day, Year) License numbe 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY ROAD TRACIE MORGAN CRNP State Registrar

NOVEMBER

BOYCE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Marion November 92 2014 1316 Clara Bet.z Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Center Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day) 9. Birthplace (State or Foreign Funeral Months 212 07 1859 Days Hours Director 1 🗆 M 2 🔀 F 91 November 24 1919 Baltimore, MD 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Baltimore Maryland 1 🗌 Yes 2 🏿 No Baltimore County 10e. Street and Numbe Zip Code 10g. Citizen of What Country? 21206 USA 715 Elmwood Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Yes. Give White 3 XWidowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 Elementary/Secondary (0-12) Homemaker Housekeeping-Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental h ပ Gertrude Barbara Schaffer Algie Leroy Turner Sr and 2 should be Health and Mer tem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 Elmwood Avenue Baltimore, Mary Land 21206 19a. Informant's Name/Relationship (Type, Print) Janet Betz (Daughter) permit, Page 1 and Department of Healt Important: If item 2 any injury or other t 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 4 Donation 5 Other (Specify) Metro Crematory Baltimore, Maryland November: 17 2011 21. Signature of Funeral Service Licensee Lassahn Funeral Home Inc 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and De-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest Immediate Cause (Final Physician/ Due to (or as a consequence of): disease or condition sen Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Due to (or as a consequence of): physician ar resulting in death) Last Physician/Medical that the death certificate be as IF FEMALE: nse yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 No Por Month Pregnant at time of death 1 | Yes 2 | 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Physician: The law requires Completed 1 Yes 2 No 3 Probably 4 Linknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? perform 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 100 ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes Certificate: 28d. Describe how injury occurred or Attending **□** Natural injury 5 Pending 24 hours after death. Funeral Director: A Accident 2 No Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Hospital Medical 29a. Certifier 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) To the within To the 29b. Signature and 29c. License number 29d. Date signed (Month. Dav. Year. 7-1040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 701 35 NCHARIFS 4105 RALTIMORE

DHMH 17 Rev 06-2011

Registrar

Box 68760

P.O.

of Vital Records,

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 9:30A. November Day 14, 2011 Physician/ Frances W. Brown Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Anne Arundel 4b. City, Town, or Location of Death **Examiner** 100 Ferndale Avenue Glen Burnie 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth Social Security Number 238-38-2687 **Funeral** 1 🗆 M 2 🗙 F 82 Months Days Hours Dec. 31,1928 North Carolina Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 1 Tes 2 X No Glen Burnie Maryland Anne Arundel 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21061 100 Ferndale Avenue 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 Nidowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o Fannie Carringer Lee Andrea Wright permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 100 Ferndale Avenue, Glen Burnie, Maryland 21061 Catherine Cruz - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation, Inc. 11-16-11 Hanover, Maryland 22. Name and Address of Facility Marzullo Tuneral Chapel, p.A. 21. Signature of Funeral Service Licensee 6009 Harford Road, Baltimore, Maryland 21214 markelle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ STENOSIS AOLTIC Medical Due to (or as a consequence of) Examiner trial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury erebro vancular that initiated events resulting in death) Last Physician/Medical that the death certificate be c brages tive attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 No 9 Unknown Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ COPD, Parkingon's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 2 1 ^-Certificate: 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box P.O. Records, of Vital To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After Division

Baltimore, Maryland 21215-0036

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

Medical

29a. Certifier

ANDLEW GOLDON 2003 Myclefel May 8k 100 ANNAPOLIS, MD 2140,

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

D31997

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		For State Registrar		State of	iviaryiar		tificate (Mental Hy	Reg. No.	201	1 3671		
		Decedent's Name	e (First, Middle	e, Last)						2. Date of De	ath		3. Time of Death		
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or ite		 Marital Status Never Marri 	ent Ever in U. es? ⊵ □ No	1f	Yes, specify	Cuban, M	exican, Puerto	ecify Yes or No- Rican, etc.)	'	 Race - Ame Black, White 	te, etc.				
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ild be Menta narked	10			Johnny	Bailey						Mary \	Vatts			
2 shouth and the and traum		19a. Informant's Na		hip (Type, Print)			g Address (Si		_	al Route Number, City or Town, State, Zip Code) Baltimore, MD 21201					
f Healf		20a. Method of Disp	position		20b. I	Place of Dispos	sition (Name	of	,	Date		eation - City o	r Town, State		
Page nent o ant: If Iry or		1 ☐ Burial 2.4 ☐ Donation	Cremation 5 🔲 Other (3 Removal from S	tate	metery, crem Metro C	natory or othe rematory,		Nov	17, 2011	C	atonsvil	le, Maryland		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		21. Signature of Ful	neral Service I	Licensee	0	22	. Name and A	ddress of	Facility ers Funera	l Service, P more, Md 2	. A				
BD = # 0		23a, Part 1, Enter t	the disease, or	r complications that c	used the deat	th. Do not ente							Approximate		
Physician/		shock, or hear Immediate Cause (rt failure. Li st i Final	only one cause on earl	line							0 -	Interval Between Onset and Death		
Medical		disease or condition resulting in death)	on	Due to (or	as a conseq	uence of):	110	سارين	MARY	dist	-				
Examiner	Į.	Sequentially list co		b. ———											
ed isit	Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or iinjury													
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	Physician/Medical														
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attend for us	cian	23b. Was decedent in the past 12 i 1 Yes 2	months?	1 Live B	rth 2 Fet	al death 3 🗆	Ectopic pre				2	23d. Date of delivery Month Day Year			
the de by the ached	hysi	9 Unknown		9 🗌 Unkno	wn										
s that igned I be det	þ	Part II. Other signif	ficant conditi	ons contributing to dea	ath but not res	sulting in the u	nderlying cau	se given i	n Part I.		-	_ / _	o the cause of death?		
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sician: The law i certificate has t irector, page 2 s	Be Co	25. Was case referre	ed to medical					26. Place	of Death (Chec	1 Yes	2 NO	1 L Ye	es 2 No		
nysicia nis cert direct	To B	examiner? 1 🗌 Yes 2 🌡	No	Hospital:	patient 2	ER/Outpatien		Other:		ome 5 🗆 Resi	dence 6	☐ Other (Spe	cify)		
ing Pt		27. Manner of Death	h 5 🗌 Pendi	28a. Date of (Month)	injury , <i>Day</i> , <i>Year</i>)	28b. Time of injury		Injury at work?		28d. Describe	how injury	occurred			
ttend death ctor: / y the f	Certificate:	2 Accident 3 Suicide	6 Could		f Injury - At h	ome, farm, stre	M eet, factory, o		2 🗆 No	28f. Location (Street and	Number or R	ural Route Number.		
al or A s after it Direct		4 L Homicide	detern		, etc. (Specif						on (Street and Number or Rural Route Number, Town, State)				
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	☐ Medical I	g Physician: To the bes	of examination	n and/or invest	igation, in my	opinion, d	eath occurred a	t the time, date	and place,	and due to the	cause(s) and manner stated		
o the vithin 2 o the comple	Š	only one) 3 29b. Signature and		g Nurse Practioner: To	the best of m	iy knowledge, c		at the tim		ce, and due to the		and manner a signed (Mon			
F > F 0		Phase services	a lo	100			D	55	3771		Nove	noa	9, 2011		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 11 Cekolin Renate 2011 8:40 A M 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Anne Arundel Glen Burnie 324 Johnson Farm Road 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth 6. Sex Days 1 M 2 X F 11-13-1926 Germany Yrs 216-30-5106 85 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Glen Burnie 1 🔀 Yes 2 🗌 No Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21061 324 Johnson Farm Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? 1 Yes 2 X No Black White etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2x No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired Elementary/Seconday (0-12) College (1-4 or 5+) 12th Computer Analyst Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Irene Johanna Melitta Jahn Jakob Anton Malsy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 324 Johnson Farm Road, Glen Burnie MD 21061 Ivanhoe Tucker (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State cemetery, crematory or other place) Ardent Cremation 11/17/2011 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility Latimore Funeral Services, 2818 E. Baltimore Street, Baltimore MD 21224 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

Physician/ Medical Examiner

Physician/

Medical

10a. State

MD

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Funeral

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31. Date filed (Mo

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permit. Page 1 and 2 should be filed within 72 hours after death a Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu

Baltimore, Maryland 21215-0036

with the Maryland

burial-transit and attending physician a for use as the burialsigned by the a page 2

by Physician/Medical funeral director, Be ျ Medical Certificate:

To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending abusing completed filled in by the

Division of Vital Records, P.O. Box 68760

Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a consequence of):	Oue to (or as a consequence of):										
Sequentially list conditions, if any, leading to immediate	b. Due to (or as a consequence of):											
Cause (Disease or linjury that initiated events resulting in death) Last	c. Due to (or as a consequence of): d	c. Due to (or as a consequence of):										
IF FEMALE: 23b. Was decedent pregnant 1												
	contributing to death but not resulting in the underly	ing cause given in Part I.		use contribute to the cause of death?								
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? o 1 □ Yes 2 □ No								
25. Was case referred to medical	1	26. Place of Death (Check	only one)									
examiner? 1 🗌 Yes 2 🙀 No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐	G ☐ Other (Specify)										
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation		28c. Injury at work? 1 Yes 2 No	28d. Describe how injury occurred									
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	1 286 Place of Injuny - At home farm etreet tag	d Number or Rural Route Number, e)										
(Check 2 Medical Exam	ysician: To the best of my knowledge, death occure niner: On the basis of examination and/or investigation rse Practioner: To the best of my knowledge, death o	, in my opinion, death occurred at t	the time, date and place	e, and due to the cause(s) and manner stated								
29b. Signature and title of certifier		29c. License number	29d. Da	te signed (Month, Day, Year)								

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325 HOSPITAL

SURVIE, MI

November 16,2011

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DHMH 17 Rev 7/2009

State Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CHANEY

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

9□Unknown 9□Unknown											
Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying	cause given in Part I.	23e. Did tobacco	use contribute to the cause of death?						
Hypertension	1			1 ☐ Yes	2 No 3 Probably 4 Unknown						
Stroke				24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of						
Seizure	disorder			performed? 1□ Yes 2 🔼	death? 1 □ Yes 2 ☑ No						
25. Was case referred to medical			26. Place of Dea	th (Check only one)							
examiner? 1 ☐ Yes 2 <mark>反</mark> No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 ☐ □	OOA Other: 4 Nursing H	lome 5 ☐ Residence	6 □Other (Specify)						
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in	jury occurred						

CVW

29c. License number 29d. Date signed (Month, Day, Year) 00063176 November 14, 2011

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6 ☐Could not be

Ballard Avenue Baltimore Maryland. Mienyenwa 31. Date filed (Month, Day, Yea 201 Nwachinemere, ma Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

၉

2 Accident

3 ☐ Suicide

29a Certifier

4 ☐ Homicide

29b. Signature and title of certifier

Certification:

Medical

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov 12, 2011 11:42a M Ruth A. Collins Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A **Baltimore** Maryland General Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1.42am Months Days (Month, Day, Year) Oct 31, 1935 Country) 1 🗆 M 2 💆 F 254-56-9677 76 Director dence of Decede 28a-f shov 10d. Inside City Limits 10a. State any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 □ No **Baltimore** MD **Baltimore City** 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code items 23a or Funeral U.S.A. 21201 453 Manse Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc 132 ò þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black If Yes, Give Year or Dates Specify: than "natural", Completed 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business/Industry life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Restaurant Worker** Restaurant 12 permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Carrie Hankins **Harold Hankins** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1519 Madison Avenue Baltimore, MD 21217 Shaunta Alston 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Nov 18, 2011 Catonsville, Maryland Metro Crematory, inc. 4 Denation 5 Other (Specify) 21. Sign ware of a neral Service Lice 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 (0 Do not enter the mode of dving, such as cardiac or respiratory arrest Part 1/Enter the disease, or complications shock, or heart failure. List only one cause hter the disease, or complications that caused the deat Approximate Interval Between Onset and Death n each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Esquentially liet conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir Cause (Disease or injury that initiated events resulting in death) Last and burial-tra Due to (or as a consequence of) attending physician I for use as the buris Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death ed by the a detached f 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Records, Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has l autopsy Division of Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 1 Yes ျှ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After the letely filled in by the funeral . Manger of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural work?
1 Yes 2 No Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 24

To the F

complet 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 60 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month LEMAN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 7. Age (In yrs. last birthday) Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 📈 F 89 Months Hours Min. (Month, Day, Year) Country) AL Director 02-22 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD **Baltimore City Baltimore** 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral U.S.A. 2814 East Federal St. 21213 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🗷 No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black If Yes, Give 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Dietitian **Public School** 12 permit. Page 1 and 2 should be filed v Department of Health and Mental Hyg Important: If item 27 is marked othe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alex McAlpine Mattie Collins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth Coleman 2814 East Federal Street Baltimore, MD 21213 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Nov 21, 2011 Owings Mills, Md. **Garrison Forest Veterans** 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 any rt 1 Firler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, such, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition « Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicial. for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Pregnant at time of death 5 Other (specify) Month Day Year g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PERTENSION 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an completed filled in by the funeral director, page 2 autopsy perform 2 🗌 No 2 K N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 Tes 2 🗶 No Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 🗌 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 11.14,2011 0025995

120

Registrar
DHMH 17 Rev 7/2009

State

BATIMONE MD 2121

se of death (Item 23a) (Type, Print)

32. Registrar's Signatu

of person who completed ca

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) November Day 2 Physician/ 5:52 Lee Carey Betty Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sinai Hospital of Baltimore Baltimore 8. Date of Birth 9. Birthplace (State or Foreign 5 Social Security Number 6. Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** 1 🗆 M 2 🔀 F Days Hours Min Year) 1927 Months Yrs Mary Land 84 Sept Director 215-24-7328 Usual Residence of Decede or 28a-f show notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No MD Owings Mills Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be re-Funeral U.S.A. 21117 8 Harmon Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Greater Balto.Med.Cntr. Executive Assistant and Mental Hygier is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be 1
Department of Health and Menta.
Important: If item 27 is marked.
any injury or other traumatic eve ပ Fletcher Hunter Melvin Edna Donahue 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Owings Mills, MD 8 Harmon Road Robert L. Carey Husband altimore, 20a, Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/22/11 4 Donation 5 Other (Specify) Owings Mills, MD Garrison Forest Vet. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road See ensons ELINE FUNERAL HOME Reisterstown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Left barai ganglia hemorrhage with intraventricular hemorrha Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) 10 days Examiner Pheumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Pleurus effusion Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hypertension Division of Vital Records, P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No
9 Unknown ď Day Year Month Pregnant at time of death the per signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Abdominal dortic aneurysm 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 25. Was case referred to medical 26. Place of Death (Check only one) director Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) s after death.

al Director: After this contained in by the funeral director. 2 No 1 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ္ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined within 24 hours a To the Funeral C Medical 1) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Fractioner: To the best of my morning of the product of the cause (s) and manner stated. (Check

State

Jinai Hospital of Baltimore, 2401 W. Beivedere Ave. Baltimore, ND 11215 JAY FOREMAN, MD 31. Date filed (Month, Day, Year,

NOV 1

Umn 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of gertifier

32. Registrar's Signature

Registrar

29c. License number

29d, Date signed (Month, Day, Year)

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	_		State Ameno Registrar 1. Decedent's Name (First,		State of M s 28a-c p	er dr	· · · · · · · · · · · · · · · · · · ·	ate of t	eath	2. Date of		<u>. 201</u>	1 3672	4
	Physicia Medi	cal	4a. Facility Name (if not inst	iB.	. Dav	is_				Nonth	nber	2 201	1 3014 W	
	Examir		SAINT	Agne	es Hos	tigs	Al	BAC	Location of D	ve	4	c. County of De	ath	
	Funeral Director		5. Social Security Number 212-34-268		М 2 1 Д F 7. Ag	77 las	Yrs. If U	nder 1 Year ths Days	If Under 24 I Hours N	lin. 8. Date of			irthplace (State or Foreign ountry)	
	Maryland Ba-f show tified at	rector	Usual Residence of Decede 10a. State 10b. C			10c. City.	Town or Location	iore					10d. Inside City Limits	
	with the I 23a or 2 ust be no	Funeral Director	3800 Silve	in I	rive			Zip Code	07		10g. C	itizen of What C		_
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho amy injury or other traumatic event, the Medical Examiner must be notified at once.	ξ.	11. Marital Status 1 Never Married 2 3 Widowed 4 Div	Married 1	2. Was Decedent I Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		If Yes,	ecedent of Hi	spanic Origin? n Mexican, Pu	(Specify Yes or Nerto Rican, etc.)	10-	14. Race - Am Black, Wh	erican Indian,	_
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, Магу	nd 2 should salth and N n 27 is ma er trauma		19a. Informant's Name Rela	L A		ler)	19b. Mailing Add	- I	and Number or	Rural Route Num	nber, City o	r Town, State, 2	Tip Code) MD 21207	_
Baltimore,	Page 1 an nent of He ant: If iten ıry or oth		20a. Method of Disposition 1		emoval from State	cer	ace of Disposition metery, crematory	of ther place		Date - 7 -		ocation - City o	r Town, State	
Balti	permit. Departr Importa any injt		21. Signature of Funeral Ser	vice Licensee	Green	المار	22. Vro	every his		reene (une	711 S	ervices	_
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4	Medical Examiner		resulting in death)	f a.	Due to (or any	conseque	nce of Huyo	corlie	I In	lentra	-		1. Inknown	
286	executed an and ial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	1 .	Due to (or as a	conseque	nce of):		C					_
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Hhir Box 687	To the hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the law and the funeral director.		F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23	c. If yes, outcome 1 Live Birth 4 Pregnant at 9 Unknown	2 Fetal of	death 3 🗆 Ector		/		-	23d. Date of d Month	elivery Day Year	
, P.O.	es that th signed by I be detac	d by Ph	Part II. Other significant co	t II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacc									o the cause of death?	
ecord	law requires the has been signer of the 2 should be	Completed by								24a. Wa	as an topsy	24b. Were a	Probably 4 Unknown utopsy findings available completion of cause of	
Sal Re	an: The la rtificate ha		5. Was case referred to med	dical				26. Pla	ce of Death (C		rformed? s 2 DN	death?	es 2 No	_
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Division o	Attending death. ctor: Afte	Certificate:	3 Suicide 6 C	vestigation ould not be	(Month, Day	TOH	injury 13 M e, farm, street, fac	work?						
Divi	or brookplate or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director.			etermined	building, etc	. (Specify)				City or T	own, State)	ural Route Number,	
100	thin 24 h	Med	only one) 3 Certi	cal Examiner fying Nurse F	an: To the best of r r: On the basis of ex Practioner: To the b	camination a	nd/or investigation nowledge, death or	i at the time, in my opinion courred at the	date and place n, death occurre time, date and	e, and due to the ed at the time, dat place, and due to	cause(s) are e and place the cause(nd manner as si e, and due to the s) and manner a	ated. cause(s) and manner state s stated.	d.
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			Jehnir	Mee	- / /	900	3a) (Type, Print)	Are	e, Bal	timere	mo	11	cause(s) and manner states s stated.	
	State Registra		1. Dale filed Month, Day, Ye NOV 1		32. Registral	r's Signature	facker							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:45 P M Samuel Lee Dougherty November 15 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Ridgeway Manor Nursing Home Catonsville Baltimore 8. Date of Birth (Month, Day, Year 5. Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Hours **Director** 1 XM 2 □ F 218-48-0554 Oct 2, 1946 65 Yrs. Maryland Usual Residence of Decedent 28a-f show 10c. City. Town or Location 10d. Inside City Limits Completed by Funeral Director Y Yes 2 No Catonsville Maryland Baltimore 10e. Street and Number 10f Zip Code 23a or 10g. Citizen of What Country? Examiner must be 21228 USA 5743 Edmondson Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1X Yes 2 No 1964
If Yes, Give
Year or Dates. Black, White, etc. "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 X Widowed 4 ☐ Divorced er than "natura , the Medical E 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. C & P Telephone Co Engineering Assistant 27 is marked other r traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eleanor Crockett Samuel Dougherty 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Nelson, Daughter 2117 Edmondson Avenue Catonsville, Maryland 21228 Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/18/11 4 ☐ Donation 5 ☐ Other (Specify) Good Shepherd Cemetery Ellicott City, Maryland Signature of Funeral Service Licensee Thomas Gregor 22. Name and Address of Facility
MacNabb Funeral Home P.A.
301 Frederick Road Catonsville, Maryland 21228 23a. Part 1. Enter the diseas, or complice shock, or heart failure. List only one Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Demention Multi-moret disease or condition resulting in death) Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) that initiated events Due to (or as a consequence of) resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the buria Be Completed by Physician/Medical P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Diabetes, Posipheral Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? Depression 24a. Was an 2 N 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 M No Hospital Other: မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature and title of certifier D2754 ▶ Creebron November 16,2011 Kayon WI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21227 GEETHA RAJA 4867 Hollins Fern, Rd MD

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Jeneen Dunn 11-08493

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jnk Unk		State of Maryland / Department 1- For Stata Registrar Certificate		, 0	2011 3672			
Physici Medical Exami		JENEEN DUNN		November	Day Year 0004 has			
		Facility Name (if not institution, give street and number) 7000 Arundel Mills Blvd.	4b. City, Town, or Location of Dea Hanover	Hanover Ar				
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Months Days House M		n(MM/DD/YYYY) 9. Birthplace (State or Foreign Country) NY			
10re, MD 21215-0036 sges I and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Hygiene. It If item 27 is marked other than "natural", or items 23a or 28a-f show any other traumatic event, the Medical Examiner must be notified at once.	Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced If Yes 2 No 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 17. Father's Name (First, Middle, Last) RONALD DUNN	3ELT 10f. Zip Code 20770 Was Decedent of Hispanic Origin? (Single Free Free Free Free Free Free Free Fr	Specify Yes or Noo Rican, etc.) work done tired) ING ING IE (First, Middle, Ma	YNN			
Baltimore, MD 2. permit. Pages I and 2 should Department of Health and M Important: If item 27 is m injury or other traumatic.		RONALD DUNN (FATHER) 20a. Method of Disposition 1 M Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22 23 24 25 26 27 28 29 20 20 20 20 20 20 20 20 20	CEMETERY 11. Name and Address of Picility VA	Date 18 2011 UGHN G BATT	KERS, NY · 10701 20c. Location - City or Town, State VALHALLA, NY REENE FUNERAL SUS V, MO. 21212			
Physician ical ical pun	Examiner	23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	r the mode of dying, such as cardiac	or respiratory arres	t, shock, or heart Approximate Interval Between Onset and Death			
. Box 68760, he death certificate be exe y the attending physician a hed for use as the burial -	hysician/I	Program of time of death	Fetal death 3 Ectopic pregn.		23d. Date of delivery Month Day Year			
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Vita	<u>ක</u> ව	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien	26.Place of Death (Check of 3 DOA Other Mursin		esidence 6 🗸 Other: Scene			
Sion of Attending Ph death. ctor: After ty the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 28a. Date of Injury FOUND: Day, Year) FOUND: Nov 11, 2011 28b. Time of FOUND: Powy, Year) FOUND: Nov 11, 2011	1 Yes 2 ✔ No	28d. Describe how Subject shot	w injury occurred			
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	됬	3 Suicide 6 Could not be determined (Specify) Parking Lot		or Town, Stat 7000 Arundel M	lills Blvd., Hanover, Md.			
To the Hc within 24 To the Fu	edica	(Check only one) 2 Medical Examiner: On the bast of my knowledge, death occu	ation, in my opinion, death occurred a	I due to the cause(s at the time, date and	s) and manner as stated. d place, and due to the cause(s)			
		29b. Signature and title of certifier Carde Hilla a	29c. License number O.C.M.E.		99d. Date signed <i>(Month, Day</i> , Yea <i>r)</i> November 12, 2011			
51	3	30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD — Assistant Medical Examiner 900 W. Ba	Itimore Street, Baltimore, M	D 21223				
Sta Registr		31. Date North Day (1917) See 32. Registrate Signature						

DOWE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 9, 2011 6:25 Gwendolvn Edwards Doidge Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Rockville Montgomery Hospice Casey House Birthplace (State or Foreign Country) Social Security Number Year If Under 24 Hrs 8. Date of Birth 7. Age (In vrs. last birthday, **Funeral** Months Davs Hours (Month, Day, Year, Director 260-26-5836 1 🗆 M 2 ី F Georgia December 26, 1923 87 item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c, City, Town or Location Director 1 Yes 2 X No Rockville Maryland Montgomery 10e. Street and Number 10f, Zip Code 10a, Citizen of What Country? Funeral United States 13805 Drake Drive 20853 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 X No If Yes, Give þ Saltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 👿 No Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Augusta Vivian Ricketts Barry Digby Edwards 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth an Important: If item 27 is any injury or other trau 13805 Drake Drive, Rockville, Maryland 20853 Leslie W. Doidge / Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State November 19 1 Durial 2 X Cremation 3 Removal from State Montgomery Crematorium, Inc Bethesda, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockvile, Maryland 20850—2805 M01305 her he disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line. Approximate shock or heart failu Immediate Cause (Final Interval Between Onset and Death Physician/ Breast Cancer disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 X No Year Month Day Pregnant at time of death Unknown 9 Unknown ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law has page 2: autopsy performed? Yes 2 X No After this certificate I 2 🗆 No 1 🗌 Yes completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 X No Hospital Other: $_{4\,\square\,\,\text{Nursing Home}}$ 5 \square Residence 6 X Other (Specify) Hospiceမ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work? 1 ☐ Yes 2 ☐ No injury 5 Pending death. Accident Investigation 24 hours after death Funeral Director: Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) and t November 9, 2011 R14320 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20 V

Registrar
DHMH 17 Rev 06-2011

State

Debrah Miller,

7 2011

31. Date filed (Month, Day, Year,

CRNP,

32. Registra 's Signature

6001 Muncaster Mill Road, Rockville, Maryland 20855

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			State Registrar		Cer	tificate of D	Death	F	leg. No. Z U		36120
	Physicia Medic	al	1. Decedent's Name (First, Middle, John Thomas Do	onovan, Jr.				2. Date of Dead	8 Day 2011	Year	3. Time of Death 3:30 p _M
	Examin	er	4a. Facility Name (if not institution, s Carroll Hospice			Westmins			4c. County of Death Carroll		
	Funeral Director		5. Social Security Number 212-50-4112 Usual Residence of Decedent	5. Sex 1 ★ M 2 □ F 7. Age (In yrs. In 62	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth 12//29/14	9. Birthplace (State or Foreign Mary Tand		
Maryland 28a-f show otified at		Director	10a. State 10b. County VA Roand		y, Town or Loc anoke	cation				10	0d. Inside City Limits 1 Yes 2 □ No
Deficiency (Maryliania Z.I.Z.13-0030) permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral D	10e. Street and Number 1916 Windsor A	venue		10f. Zip Code 24015			10g. Citizen of What Country?			
	ırs atter death ural", or item I Examiner π	þ	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 🏋 Divorced	12. Was Decedent Ever in U.s Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates.	1	Vas Decedent of Hi f Yes, specify Cuba ☐ Yes 2 ሺ No	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White		
-61212	within 72 nor giene. er than "nati the Medica	Completed	15. Decedent (Specify only highes Elementary/Seconday (0-12) 12		(Give I	lent's Usual Occupa kind of work done of O NOT use retired) Care Man	luring most of work	- 1	16b. Kind of Busines Lawn Trea		
ylallu ,	d be nied view of the new of the new of the new of the tic event,	To Be	17. Father's Name (First, Middle, La John Thomas Done				18. Mother's Nam Dorothy	e (First, Middle, 1 Mae Bol	Maiden Surname t	·)	
Mary	d 2 should alth and N 27 is ma er trauma	20	19a. Informant's Name/Relationshi Kenneth Donovan	p (Type, Print)	19b. Mailir 2206 <i>4</i>	ng Address (Street a Albert Ri	nd Number or Rug 11 Road F	al Route Nymber Hamps tea	d, MD 2	10 <i>7</i> 4°	Code)
partitione,	Fage 1 an nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	3 ☐ Removal from State	emetery, cren Ee Ques	sition (Name of Date 20c. Location - City or Town, State Natory or other place) Later Anatomical 11/10/11 Allentown, PA					
ספור	permit. Departr Imports any inji	1	21. Signature of Funeral Service Light	rangello-	es of Facility Man	zullo F Baltimor	uneral e, Mary	Chape Land	21. P.A. 21214		
p	h _y sician/ Medical	200	23a. Part 1. Enter the disease, or o shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	complications that caused the deat ly one cause on each lin. aa Due to (or as a consequence)	vd /	er the mode of dying	g, such as cardiac		est,		Approximate Interval Between Onset and Death
	Examiner	ler	Sequentially list conditions,	b. — Due to jor as a consequence of the consequence						_	
5	cate be executed physician and s the burial-transit	al Examiner	cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	cDue to (or as a consequ	uence of):						
00/0	physic s the b	Medical		d						_	
DOX 00	To the hospital or Attenuing Frighting. The law requires that the beath certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of a 9 Unknown	al death 3	Ectopic pregnand Other (specify)	sy		23d. Da Mo	te of delive	ery Day Year
JS, F.O.	in signed by uld be detac	by	Part II. Other significant condition	ns contributing to death but not res	sulting in the u	ınderlying cause giv	ven in Part I.				ne cause of death?
necorus,	cate has bee	Completed						24a. Was a autop perfor	med?	Were autoporior to coldeath?	psy findings available mpletion of cause of
ָ פ	certifi	Be C	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	FD/0 1 1/1	Oth	ace of Death (Chec		s Non	(0)6	Done
	ath. r: After this e funeral d	Certificate: To	27, Manner of Death 1 Natural 5 Pending 2 Accident Investig.		28b. Time of injury	28c. Injury	y at	ome 5 Resid			House
DIVISION	rs after de al Directo ed in by th		3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determin		ome, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number n, State)	er or Rural	Route Number,
	ine Funeri Jin 24 hou the Funeri Tpleted fill	Medical	(Check 2 Medical Exonly one) 3 Certifying	Physician: To the best of my know caminer: On the basis of examinatio Nurse Practioner: To the best of m	n and/or inves	tigation, in my opinio	on, death occurred a	t the time, date a	nd place, and du	e to the ca	use(s) and manner stated.
	North Con		29b. Signature and title of certifier	ento		29c. License	077	146	29d. Date sign	d (Month,	(Pay, Year)
	-4		30. Name and address of person w	ento 505 S	Cen	ter St.	Westm	inster	MD 0	2115	7
	Stat Registra		31. Date filed (Month, Day, Year)	32. Registrar's Signa	and I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 36729 1 - State Registrar Certificate of Death 1 Decedent's Name (First Middle | ast) 2 Date of Death 3. Time of Death Month P^{M} 2011 2:30 Kitchen Dorsey November Gertrude 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday, Days Hours (Month, Day, Year) Months 218-03-8352 1 M 2 V F Feb 9, 1918 Georgia 93 Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 1 Yes 2 X No Maryland Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21204 1055 W. Joppa Road, apt. 533 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🛣 No If Yes, Give 1 Never Married 2 Married 1 Yes 2 X No Specify Specify: 3 X Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Account Certified Public Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Heath Ardelle Kitchen Ruby 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Chadwick Road, Lutherville, MD 21093 Corinne Dorsey Onnen/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 11/18/11 Donation 5 Dother (Specify) Dulaney Valley Memorial Gardens Timonium, Maryland Lemmon Funeral Home of Dulaney Valley Inc. 10 W. Padonia Road, Timonium, MD 20193 W. clary Bryan 23a. Part *. Enter the disease, or complifations that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate sho k, or heart failure. List only of nterval Betweer Onset and Death Immediate Cause (Final disease or condition resulting death Gilit Due to lor as a consequence of Due to (or as a consequence of)

Physician/ Medical Examiner

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attending physiciar

signed by

has le 2

s after death. I Director: After the

To the Hospital within 24 hours a To the Funeral C Hospital

by

Completed

Be

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Certificate:

certificate be Box 68760

Division of Vital Records, P.O.

use as the burial-tran

Department of Important: If it any injury or o

Physician/

Medical

10a. State

Examiner

Funeral

Director

28a-f shov

5 ms 23a or must be r

notified at

Examiner

27 is marked other than "natural", traumatic event, the Medical Exar

h and Mental F

and 2 s Health

o.

Baltimore, Maryland 21215-0036

Director

Completed by

ပ

Exami Caose (Disease or injur that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No

9 Unknown

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying

Due to (or as a consequence of):

Unknown

Day

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cercla rovascular disease esophageal vicers with Gastrointernal atrial fibrillation

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown

23d. Date of delivery

24a. Was an 26. Place of Death (Check only one)

Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No 1 Yes 2 No

nespice

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death Natural

5 Pending Accident
Suicide Investigation 6 Could not be 4 Homicide determined

1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28a. Date of injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at work? 1 ☐ Yes 2 ☐ No M

28f. Location (Street and Number or Rural Route Number,

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination investigation, in my spinion, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29b. Signature and title of certifier

058303

29d. Date signed (Month, Day, Year) November 16 2011

6701 N. Charles ST Towson MA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANNE NO ARRON

Hospital:

31. Date filed (Month,

32. Registrar's Signature

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36730 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death $\begin{array}{ccc} \text{NOVEMBER} & \text{Day} \\ 13 & 2011 \end{array}$ Physician/ **ESSEX** SR. LARRY 11:00 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** PRINCE GEORGE'S 2140 BROOKS DRIVE # 120 FORESTVILLE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Hours Min NOV . 16 LA Country 1 🕅 M 2 🗆 F 65 571-64-6574 1945 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene.
27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1x Yes 2 □ No PRINCE GEORGE'S FORESTVILLE MD 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20747 <u> 2140 BROOKS DRIVE #120</u> 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc 1 Never Married 2 Married by 1 ☐ Yes 2 🌠 No If Yes, Give Baltimore, Maryland 21215-0036 BLACK 1 ☐ Yes 2 X No Specify 3 Widowed 4 Divorced Specify. Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed, Elementary/Seconday (0-12) College (1-4 or 5+) of Health and Mental Hygien fitem 27 is marked other th PRIVATE MEAT CUTTER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ပ **EMMA** LEWIS GUSSIE ESSEX 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 10703 POOKEY WAY UPPER MARLBORO, MARYLAND 20774 DELORES JACKSON ESSEX/EX-WIFE 20a. Method of Disposition
1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ott RESURRECTION CEMETERY 11/18/2011 CLINTON, MARYLAND 4 Donation 5 Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME, INC. 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1/Enter/the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failt Interval Between Onset and Death STROKE Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): sician and lŭ Due to (or as a consequence of): attending physiciar Physician/Medical certificate be P.O. Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown бo Month Day Year the detached ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? à Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ☐ Yes 2 😾 No Yes 2x No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 X No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number D 00 68 4 18 29b. Signature 29d. Date signed (Month, Day, Year) ၉ 2011

Registrar

State

23a) (Type, Print)

1221 MERCANTILE LANE LARGO, MARYLAND 20774

30. Name and address of person who completed cause of death (Item CHR ISTOPHOTE PASCE

32.

Registrar's Signature

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36731 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 3:15P M Physician/ Mari Finner 201 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Examiner 4031 Grantley Road Ballimore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number **Funeral** Hours Min. 220.30.495 Director 1 □ M 2 X,F 30 1932 10d. Inside City Limits 28a-f shov 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10b. County Director Baltimore MD 1 XYes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA Grantle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Nas Deceue... Armed Forces? No 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status 1 Never Married 2 Married Completed by Black Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Social Security permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic. Elementary/Secondary (0-12) Administration ban Examiner (2th grade) Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henson ည Otho Mackar Jabel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elderwood Court Eldersburg MD 21 J. Hughes Pamela 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 19/2011 Windsor Mill, MD King Memorial 4 ☐ Donation 5 ☐ Other (Specify) Vauym C. Gueene Funeralverlices 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 8728 Liberty Road Randallstown MD 21133 23a. Part 1. En er the disease, or complications that caused the death. Do not enter the mode of dying, she as cardiac or respiratory arrest, shock, or eart fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fillal Ph_sician/ disease or condiallie MICUI Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the 38 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No ģ Day Pregnant at time of death been signed by the a should be detached t g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o Q 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown 1000 4001-600 Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an per lipidemi autopsy performed? Yes 2 No has after death.

Director: After this certificate 1 ☐ Yes 2 ☑ No To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? 1 ☐ Yes 2 🗷 No Other: 4 \square Nursing Home 5 \bowtie Residence 6 \square Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 🗷 Natural 5 Pending work?
1 Yes 2 No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral D

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) IDV

State

Registrar

31. Date filed (Month, Day

Year,

NOV 1

Car's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 14 2011 Physician/ 11:55A ^M NOVEMBER FISH Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE EMERITUS AT PIKESVILLE PIKESVILLE Birthplace (State or Foreign Country) 8. Date of Birth If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** (Month, Day, Year) Min. Months 213-16-3585 1 🗆 M 2 🔀 F **Director** MD 10/12/1920 91 Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 🗆 Yes 2 🏝 No PIKESVILLE BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral USA 21208 1840 REISTERSTOWN ROAD 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give 1 Never Married 2 Married þ 1 ☐ Yes 2 H No Specify: Maryland 21215-0036 WHITE 3 X Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) OWN HOME 12 HOMEMAKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည UNKNOWN CHAZEN GOLDIE JOSEPH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2828 QUARRY HEIGHTS WAY, BALTIMORE, MD 21209 SUSAN KURLANDER/DAUGHTER Baltimore, 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place) 1 N Burial 2 Cremation 3 Removal from State 11/16/2011 BALTIMORE, MD MOSES MONTEFIORE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. f Funeral Service 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e on each line. 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one cause Approximate Interval Between Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year ρ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death detached 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes 2 26. Place of Death (Check only one) Be 25. Was case referred to medical funeral director, examiner? Hospital Other: 2 1 NO 4 Nursing Home 5 Residence 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 6 Y Other (Specify) မြ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural work? 1 ☐ Yes 2 ☐ No 5 Pending hours after death. neral Director: Aft y filled in by the fur Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined on 24 hours

o the Funeral Decompletely filler Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Defining Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar

(Check only one

29b. Signature a

30. Name and addr 0 31. Date filed (Mont leted cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS. G921, 11/17/2011, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death cedent's Name (First, Middle, Last) 2. Date of Death Wember Year Physician/ Romona A. Horne Felton 00 TOY HE 2011 Medical 4c. County of Death **Examiner** acility Name (if not institution give street and number or Location of Deat 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** Min 1 DM 2 DF Director 216-94-3106 45 Md. Nov 28, 1965 ems 23a or 28a-f show r must be notified at 28a-f show 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland Director 1 X Yes 2 No MD **Baltimore City Baltimore** 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 802 North Lakewood Avenue U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Medical Examiner Black, White, etc. ō ģ 1 Never Married 2 Married Saltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 No Specify: Black Specify: "natural" Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Chef Olive Garden 12 of Health and Mental Hygie If item 27 is marked other ir other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lena Horne **Curtis Daughtry** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Reginald Felton 802 North Lakewood Avenue Baltimore, MD 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State Baltimore, Md. Western Cemetery Nov 16, 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura Funeral Service Lice 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one carries on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner (or as a consequence of): burial-transi Cause (Disease or injury that initiated events resulting in death) Last LUNSION and o (or as a consequence of) attending physician I for use as the buria To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death been signed by the s should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an page 2 autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Yes 2 No ပ ▼Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North Wolfe ST, Baltimore Mary State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36734 1 - State Registra Certificate of Death _ate c Month 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 15^{Day} Physician/ 2011 P^{M} 2:22 Gelaro Glynnis Ann Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Howard Columbia Gilchrist Hospice Care Columbia If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 🗆 M 2 🔀 F Hours Min (Month, Day, Director 54 1957 Pennsylvania Nov 200-44-3749 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho tranmatic event, the Medical Examiner must be notified at Director 1 🗌 Yes 2 🛛 No Elkridge Maryland Howard 10f. Zip Code 10g. Citizen of What Country? Funeral United States 5925 Sandy Ridge 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1. Marital Status Black White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: WHITE 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 ! and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Speech Pathologist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ann Souchak Robert Schaar 1 and 2 should be of Health and Meritem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5925 Sandy Ridge, Elkridge, Maryland 21075 Ronald Gelaro - HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-16-2011 Baltimore, Maryland Metro Crematory Inc 22. Name and Address of Facility Cremation Society Of Maryland INC ature of Funeral Service Licensee 299 Frederick Road, Baltimore MD 21228 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Metastatic Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☑ No Year Pregnant at time of death 1 L Yes 2 1 9 Unknown be detached P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed should . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has death? 1 Yes 2 No 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, i 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 4 Nursing Home 5 Residence Hospice ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Sther (Specify) 28b. Time of 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred Certificate: or Attending (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No М 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Hospital 1 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

6336 CEDAR LANE, COLUMBIA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

JOSEPH

31. Date filed (Month, Day, Year)

NOV 1

D0060634

11/16/11

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36735 for State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 12ay2011 Year 8:37 p M Dorwin E Grise 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 11661 Asbury Circle Solomons Island Calvert # 559 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Hours (Month, Day, Year) Months 1 **X** M 2 □ F 92 November 27 1918 Michigan 10b County 10d. Inside City Limits 10c. City. Town or Location Calvert Solomons 1 Yes 2 XNo 10f. Zip Code 10g. Citizen of What Country? 20688 LISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. If Yes, Give Year or Dates. 1 Yes 2 X No Specify: Specify: White WW II 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Engineering Baltimore Co. Public Works 18. Mother's Name (First, Middle, Maiden Surname) Margaret Buxton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11661 Asbury Circle # 559 Solomons, Md. 20688 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Metro Crematory November 21 2011 Baltimore, Maryland ure of Funeral Service Censee ²²Lassanh dunetār Home Inc 7401 Belair Road Baltimore, Maryland 21236 n. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ostat 2 Cancer Due to (or as a consequence of) Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Month Day Year Pregnant at time of death 2 🗌 No g Unknown 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Social Security Numbe 540 20 2331 **Funeral** Director Usual Residence of Decede 28a-f shov 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland 10e, Street and Number Funeral 11661 Asbury Circle #559 11. Marital Status item 27 is marked other than "natural", or other traumatic event, the Medical Examin þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed 3 Widowed 4 Divorced giene. Elementary/Secondary (0-12) 2 should be filed with h and Mental Hygien 7 is marked other tl Be 17. Father's Name (First, Middle, Last) ၉ Verbie Grise 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st Department of Health ar Important; If item 27 is any injury or other trau Joyce Grise (Wife) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed and -trar resulting in death) Last burialphysician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23b Was decedent pregnant in the past 12 months? 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? Yes 2 No death? certificate 1 Yes 2 No Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 25 No Other: ၉ 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred iniurv work?
1 Yes 2 No 1 Natural 5 Pending Accident ours after death.

eral Director; Aft
filled in by the fur Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 24 hours Medical Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0055547 5 no completed cause of death (Item 23a) (Type, Print). 888 Bestgate Road Suite 111 Annapolis, Maryland 21401 6×11 Ruth A Robinson 31. Date filed (Month, Day, Year) State

Registrar

Physician/

Medical

Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Nov 9, 2011 Year 8:30a M Physician/ Dorothy A. Greene-Johnson Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel **Curtis Bay** 4245 Pascal Avenue 5. Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Months Days Hours Min. (Month, Day Year) Apr 19, 1945 Country) NC 239-78-5750 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits with the Maryland event, the Medical Examiner must be notified at 10c. City. Town or Location Director 1 Yes 2 No **Curtis Bay Anne Arundel** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Completed by Funeral U.S.A. 23a 21226 4245 Pascal Avenue items ? Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status Race - American Indian. Armed Forces?
1 ☐ Yes 2 🗷 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ö 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 ☐ No Specify: **Black** If Yes Give "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) A. A. County Schools **Director Child Care** 12 Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Sadie H. Teague Robert Greene injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 4245 Pascal Avenue Curtis Bay, MD 21226 Jacqueline Mayers 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Brooklyn Park, Md. Nov 15, 2011 **Cedar Hill Cemetery** 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Eury the disease, or complications that caused the shock, of eart failure. List only one cause on each line. Approximate Interval Between Onset and Death) h. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician. disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No Year Month Day Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 □ Unknown 2 No 1 Yes Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s autopsy perform 1 ☐ Yes 2 ☐ No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 2 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Accident 2 No Investigation after death Director; Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined 24 hours a Funeral L Medical 29a. Certifier ᢏ ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Getting huma Prediction: It this basis of my included a date occurred at the time, date and place, and due to the cause (t) and manner as stated. (Check

within 2 29b. Signature and title 29c. License number 29d. Date signed (Month. Dav. Year) and address of person who completed cause of death (Item 23a) (Type, Print) 32. Regis Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Degedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12:06 PM Medical Facility Name (if not institution, give street and number) County of Death 4b. City, Town, or Location of Death **Examiner** 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Min Hours Director MD permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural". "" any injury or other traumatic event the properties." 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 21212 USA Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces , ∟ Yes 2 If Yes, Give Year or F 1 Never Married 2 Married 1 Yes 2 No Specify 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) onglary (0-12) College (1-4 or 5+) Be ather's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname ပ Informant's Name/Relationship (Type, Print) to.MD21212 Method of Disposition 20b. Place of Disposition (Name of City or Town, State Date crematory or other place, Burial 2 Cremation 3 Removal from State 4 Donation 15 Other (Specify 21. Signature 23a. Party Enter the disease, or complications that caused the death. Do not enter the shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician/ etmantion disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Due to Dices a consocuence of: the burial-transi Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month Day Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.3 autopsy 1 Yes 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 100 1 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Tother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending death. Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature an 29c. License number MD D7104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 Noch

State Registrar Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 8 45 AM **Physician** 2011 10 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner CARE BALTIMORE RALTIMOR & 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 11–21–1953 Birthplace (State or Foreign Country) Social Security Number **Funeral** Months Days Hours Min. 1 M 2 X F 57 218-66-1259 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examples In office at one. 10c. City, Town or Location 10a. State Yes 2□No Director BALTIMORE TURNER STATION MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 21222 USA 120 LEE LAWRENCE CT. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify. ð WHITE 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be SONIA LUCILLE JENNELL BERNARD G. GIFFORD 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) BALTIMORE, MD 21222 3522 DUNHAVEN RD. DOROTHY STEVENS/SISTER Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-15-2011 BALTIMORE, MARYLAND METRO CREMATORY 22. Name and Address of Facility JAMES A. MORTON & SONS FUNERAL HOME 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) NOCARCINOMA **Physician** /Medical Due to (or as a consequence of): Examiner ٨G Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 XXVo 5 Other (specify) P.O. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 nknown icate has been signated page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 2 □ No 2 🗆 1 ☐Yes 1 □ Yes Division of Vital Physician: : After this certific funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 ☐ Yes 1 Inpatient 2 TER/Outpatient 3 DOA Certification: To 28d Describe how injury occurred Date of Injury (Month, Day, Year) 28b Time of 27. Manner of Death 28c. Injury at Work? Hospital or Attending Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death. 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated within 2. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HBayview ARLENE FUCHS your

DHMH 17 Rev 1/200

State Registrar 31. Date filed (Month, Day, Year)

32 Registrar's Signature

1-08409		Please Type or Print in Black Indelik		_	ible.	
ay S. Horner		State of Maryland / Departme	nt of Health and Mental F <i>te of Death</i>	lygiene	201	1 3673
Physici	an/	Registrar 1. Decedent's Name (First, Middle,Last)	le oi Dealli	Reg	g. No.	3. Time of Death
nedical Exami		Ray S. Horner		Month November	Day Year 9, 2011	1028 hrs
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Deat		4c. County of Death	
*		5501 O'Donnell Street Cutoff	Baltimore			
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthe	day) If Under 1 Year If Under 24Hr Months Days Hours Mir	s. 8. Date of Birth	(MM/DD/YYYY) 9. Birt 24,1952 Foreig Cou	hplace (State or
Director		434-88-9023 1XM 2F 59	Yrs.	march 2	24, 1954 Co.	untry LOUISalla
yn e		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	r Location			10d. Inside City Limits
	L	LA Port A	llen			1 Yes 2 No
aryland 8a-f show at once,	Director	10e. Street and Number	10f. Zip Code	109	g. Citizen of What Coun	itry?
ith the Maryland 23a or 28a-f she	Ö	5526 Poydras Drive	70767		USA	
with ms 23	era		13. Was Decedent of Hispanic Origin? (S		14. Race - Americ	can Indian, Black,
death or ite	Funera	1 Never Married 2 X Married Armed Forces? 1 X Yes 2 No	If Yes, specify Cuban, Mexican, Puerto	o Rican, etc.)	White, etc.	
s after	β	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 X Yes 2 No specify:		Specify: Whi	
2 hour	ted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	ecedent's Usual Occupation (Give kind of uring most of working life. DO NOT use rel		16b. Kind of Business/Ir	ndustry
336 thin 7; than edical	nple	12 0 t	truck driver	h	Hunt Transp	ortation
215-0036 be filed within 72 hours after ntal Hygiene. rked other than "natural", ent, the Medical Examiner	Completed	17. Father's Name (First, Middle, Last)	18.Mother's Nam	e (First, Middle, Ma	aiden Surname)	
be fill ricked	Be	Ramie Anthony Horner		ivian Vi		
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23s or 28s-f sh r tranmatic event, the Medical Examiner must be notified at once	ဠ		Mailing Address (Street and Number or 526 Poydras Bayou			
ore, MD ges 1 and 2 sho t of Health and : If item 27 in			Disposition (Name of cemetery,		20c. Location - City or	
			y or other place)		,	
Baltimo permit. Page Department or Important: injury or ott		4 X Donation See Specify: 21. Signature of Funeral Service Lices	22. Name and Address of Facility Sta	. h A h .	Danid	
Ba Perm Depa		21. Signature of Funeral Series Lice, Director	655 W. Balitmore		-	21201
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not				Approximate Interval
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a.Atherosclerotic Ca	rdiovascular Disea	se		Between Onset and Death
-Adminer		or condition resulting in death) Due to (or as a consequence of):		_		
	-e	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
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red nsit	Exa	events resulting in death) Last Due to (or as a consequence of):				
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ox 68760, ath certificate be ex attending physician or use as the burial	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of delivery	
687 ertific ding p e as th	an/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2	Fetal death 3 Ectopic pregna	ancy		ay Year
Box 68760, a death certificate be the attending physic of for use as the buri	/sic	1 Pregnant at time of death 5 No 9 Unknown	Other (Specify)			
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ords, w requir	lete			24a. Was an		opsy findings available ompletion of cause of
Recc The lay	E			perform	ned? death?	
Vital Reco ysician: The law his certificate has director, page 2 si	Be Completed	25. Was case referred to medical	26.Place of Death (Check			
Vit hysici		Tes 2 No	patient 3 DOA Other Nursin	ng Home 5 R	esidence 6 🗹 Other:	Scene
n of Viding Physi		1 X Noture (Month, Day Year)	me of Injury 28c. Injury at Work?	28d. Describe ho	w injury occurred	
SiOl Atten death ector:	Cat	2 Accident Investigation	1 Yes 2 No	00/ 1 // /0/		
Division of Vital Records, rst or Attending Physician: The law requir rs after death. a) Director: After this certificate has been seled in by the funeral director; page 2 should lead in by the funeral director; page 2 should lead in by the funeral director; page 2 should lead in by the funeral director; page 2 should lead in by the funeral director; page 2 should lead in by the funeral director; page 2 should lead the funeral director.	Certification:	Suicide Could not be determined (Specify)	n, street, factory, office building, etc.	or Town, Sta	reet and Number or Rur ite)	al Route Number, City
Div the Hospital or hin 24 hours afte the Funeral Dii npletely filled in		29a. Certifier	occurred at the time, date and place, and	due to the cause((s) and manner as state	d
Division of a To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or invitable and manner stated.				
To wit	£	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mon	th, Day, Year)
		ひして.	O.C.M.E.		November 10, 20	11
	ı	30. Name and address of person who completed cause of death (Item 23a)	000111 B. III			
		Donna M. Vincenti, MD Assistant Medical Examiner 31. Date filed (Mc Markey Year) 32 Registrar's Signature	900 W. Baltimore Street, Baltin	nore, MD 212:	23	
Sta Regist	ite rar	31. Date filed (Monthly Year) 2011 32 Registrar's Signature 3.	barker			

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OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36740 Certificate of Death 2. Date of Death 1, Decedent's Name (First, Midgle, Last) Nepler Day Month Day 12 aymond **Physician** /Medical la. Facility Name (If not institution, give street and number)
Loch Rayan Community Living 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Center Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | Feb 14, 9. Birthplace (State or Foreign 6. Sex 1 M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Pennsylvania Director 81 218-26-0464 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it is Medical Event in the traumatic event, it is Medical Event in the traumatic event. 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1X Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21222 118 Patapsco Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 XiYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 white 1 ☐ Yes 2 📉 No ð 3 → Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) automotive automotive inspector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harry James Hepler Florence Viola Morgan ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 118 Patapsco Avenue; Baltimore, MD 21222 Leslie Long – stepdaughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) e of Funeral Service Lice 22. Name and Address of Facility State Anatomy Board 21201 655 W. Baltimore St; Baltimore, MD Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line zheimers VISEASE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner OVONON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe Hospital or Attending Physician; The certificate 2 13 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Hother (Specify) 1 Yes 2 1No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 27. Mannyr of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one)

State Registrar

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3900 Lock Canada E. Wicks M.D. Baltimov

29d Date signed (Month, Day, Year) November 12, 2011

Boulevard 21218

Loch Raven

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		-	For State Registrar	State of Marylan		artment of Fi tificate of D			glerie Reg. No. 🤰	011	3671.1	
	Physicia		1. Decedent's Name (First, Middle, L	ast)				2. Date of Dea	ath Day	Year 1/ A	Time of Death	
	Physicia Medic	al	Barbara Sue Ho					1//_	14	20110	440 M	
	Examin	er	4a. Facility Name (if not institution, gi		m	4b. City, Town, or Cumber:			1	y of Death _egany		
	Farmeral			nd Health Syste		If Under 1 Year	If Under 24 Hrs.	8. Date of Birl		9. Birthplace	State or Foreign	
H	Funeral Director		219-56-9648 Usual Residence of Decedent	1 □ M 2 🗓 F 61	Yrs.	Months Days	Hours Min.	Oct II,	1950_	Mary1	and	
	and show lat	ō	10a. State 10b. County			wn or Location					side City Limits	
	Maryla 18a-f	rect	MD Alle	gany C	umber1	and				1 🗆 Yes 2 🎦 No		
	with the I s 23a or 2 ust be no	Funeral Director	10e. Street and Number 17 E. Offett S	t.		10f. Zip Code 21502			10g. Citizen of USA	What Country?		
9800	e filed within 72 hours after death with the Maryland tal Hyglene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🄀 Divorced	12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates.	11	Vas Decedent of Hi f Yes, specify Cubal ☐ Yes 2 🔀 No	n, Mexican, Puerto	pecify Yes or No- Rican, etc.)		ce - American Ind ack, White, etc. y: white		
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lan	ould be filed on the marked oth the same of the same o	유	Robert Lyons	Nesitt			Shirle	y Jeann	e Nicol	es 		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic en once.		19a. Informant's Name/Relationship Michael P. Or			19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 12245 Red Hawk Dr; Waynesboro, Pennsylva					La 17268	
more,	Page 1 an nent of He int: If iterr ry or othe		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Onation 5 Other Spe	☐ Removal from State	emetery, cren	sition (Name of natory or other plac		Date		- City or Town, S	state	
Balti	permit. Departm Departm Importa any inju		21. Signature of Funeral Service ice	Director	22	. Name and Addres	s of Facility Sta	ite Anat St; Bal	omy Roa timore,	rd MD 2120	01	
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	hysician/	8 3	Immediate Cause (Final disease or condition	LIPPY)	1, 4	EVEN	FOV	35TM	UCTIC		et and Death	
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89 89	ath certifi attending for use as	an/l	IF FEMALE: 23b. Was decedent pregnant	ncy II death 3 🗆	Ectopic pregn <i>a</i> nd	:v			Date of delivery			
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Division of Vital Records,	tal or Att	d Certificate:	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determine			eet, factory, office		28f. Location (City or To		ber or Rural Rou	te Number,	
	To the Hospital or Attending Physician. The la within 24 hours after death. To the Funeral Director: After this certificate ha completed filled in by the funeral director, page?	Medical	(Check 2 Medical Exa	nysician: To the best of my know miner: On the basis of examination urse Practioner: To the best of m	n and/or inves	tigation, in my opinio	on, death occurred	at the time, date	and place, and o	due to the cause(s)	and manner stated.	
	To t To t		29b. Signature and title of certifier	1/Lver	10	29c. License	number 0 1870	59	29d. Date sign	ned (Month, Day, 14/26)	Year)	
	,		30. Name and address of person wh	o completed cause of death (Item			land, Mo	1. 21502		•		
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Signa	ture							
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Medic Examin	al	4a. Facility Name (if not institution,	give street and number		1011IIIan	4b. City, Tow	n, or Location of [Death	Novemb	4c. C	ounty of Deat	h
Funeral Director		13414 Crispin 5. Social Security Number 368-58-4752			last birthday)	If Under 1 Y		Hrs. Min.	8. Date of Birt (Month, Day	h , Year)	Co.	thplace (State or Foreign untry)
	Director	Usual Residence of Decedent 10a. State 10b. County	gomery	10c. Ci	Yrs. ity, Town or Lo Rockv				April	19, 19	951 Mic	thigan 10d. Inside City Limits 1 □ Yes 2 🏋 No
with the M s 23a or 28 ust be noti	Funeral Din	10e. Street and Number 13414 Crispin			- KOCKV	10f. Zip Co.				10g. Citizen of What Country? United States		
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	.11. Marital Status 1 □ Never Married 2 🗓 Married 3 □ Widowed 4 □ Divorced 12. Was Decedent E Armed Forces? 1 □ Yes 2 🛍 If Yes, Give Year or Dates.					of Hispanic Origin Cuban, Mexican, P No Specify:	? (Spe Puerto l	cify Yes or No- Rican, etc.)	14 Sp	rican Indian, e, etc. Thite	
hin 72 hours ne. than "natur te Medical I	Completed	15. Deceder (Specify only highe Elementary/Secondary (0-12)	r 5+)	(Give . life. D	O NOT use reti	ne during most of red)		ng		of Business/	Índustry	
be filed wit ental Hygie ked other ic event, th	To Be C	12 17. Father's Name (First, Middle, L Willard Hoffm			Gene	rai coi	18. Mother's	s Name	e (First, Middle, Eneid	Maiden Su		yeu
nd 2 should ealth and M m 27 is mai er traumat		19a. Informant's Name/Relationsh				-	eet and Number o					
it. Page 1 a rtment of H rtant: If ite njury or ott		20a. Method of Disposition 1	pecify)	te	cemetery, crer	sition (Name o matory or other Cremator	ium, Inc	201		Beth		Maryland
permir Depar Impor any ir		21. Signature of Furieral Service L	rand 1	101305	5 30	00 West M		Aver	nue, Rock	ville,	ille, Ir Maryla	nd 20850-2805
Physician/ Medical		23a. Part / Enter the disease, or shock, or heart failure. List o Immediate Cause (Final disease or condition resulting in death)	nly one cause on each I	_{nary} /	Artery	Disease		irdiac o	r respiratory arr	est,		Approximate Interval Between Onset and Death Years
Examiner /sician and e burial-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atherosclerosis Due to (or as a consequence of): C. Due to (or as a consequence of): Due to (or as a consequence of):										
Attending Physician: The law requires that the death certificate be extractions.	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown Unknown Unknown 23c. If yes, outcome of pregnancy 23d. Date of del Month 23d. Date of del Month Month 23d. Date of del Month										livery Day Year
requires that the dea been signed by the a should be detached t	by	Part II. Other significant condition Hypertensive He	0			, ,	0			Yes 2 🗆	No 3 🗓 P	the cause of death?
sician: The law re certificate has be irector, page 2 sh	Completed	25. Was case referred to medical					2 Discost Double	(0)	1 🗌 Yes		prior to death?	topsy findings available completion of cause of
Physician: this certific ral director,	To Be	examiner? 1 Yes 2 X No 27. Manner of Death			ER/Outpatier	nt 3 🗆 DOA		sing Ho	me 5 X Resid			sify)
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Il Certificate:	1 Natural 5 Pendin Investig Accident 3 Suicide 6 Could determ	gation not be 28e. Place of I	Day, Year)	28b. Time of injury	М	njury at work? I □ Yes 2 □ N ice	lo	28d. Describe h 28f. Location (S City or Tow	Street and I		ral Route Number,
the Hospithin 24 hour thin 24 hour the Funers	Medical	(Check 2 Medical E	Nurse Practitioner: To	f examinatio	on and/or inves	tigation, in my o , death occurred	pinion, death occur d at the time, date	urred at	the time, date a ice, and due to t	nd place, a he cause(s)	nd due to the and manner a	cause(s) and manner stated as stated.
70 Wi		290. Signature and this of certilier	Ago	V		290. LIO	D25808				signed (Mont) ber 15	, 2011
IDV			1, M.D. 103	13 Ge	orgia A		Silver	Spr	ing, Ma	rylar	nd 2090	02
Stat Registra		31. Date finOV11 27 201	32. Regis	trar's Signa	park							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Florence Ruth Humbert November 10, 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Columbia r1 Year | If Under 24 Hrs. Brighton Gardens of Columbia Howard If Under 1 Year Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F **Director** 220-14-7647 88 May 2, 1923 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 28a-f show ?7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Wedical Event increase be notified at Director 1 ☐Yes 2X No MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7110 Minstrel Way 21045 United States within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Specify: þ Specify: 3 X Widowed 4 ☐ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within the and Mental Hygiene.
7 is marked other than " than Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Education permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked othin any lijury or other traumatic event ODEs. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ည Robert Edward Lee Hancock Edith Marie Stehl 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kenneth M. Humbert / Son 1239 Murray Road Odenton, Maryland 21113 20b. Place of Disposition (Name of cemetery, crematory or other place)
Crest Lawn
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11-12-2011 Marriottsville, Maryland 21. Signature of Funeral Service Ligenses 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Will Exponer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. he imers Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events Physician/Medical Examiner Due to (or as a consequence of): Physician: The law requires that the death certificate be execute burial-tran resulting in death) Last Due to (or as a consequence of) the phy as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □Yes 2 ☒ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ned by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 2 No 1 ☐ Yes funeral director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 X Other (Specify) Living 1 Yes 2 XNo Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

P.O. Division of Vital Records, or Attending s after death.

I Director: A din by the fu To the Hospital within 24 hours a To the Funeral L filled Hospital completely

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D47447 November 10, 2011 of person who completed cause of death (Item 23a) (Type, Print) 30. Name and address Andy Lazris, MD 6334 Cedar Lane Suite 103 Columbia, Maryland 21044 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar

Medical

NOV 1 7 2011

8

parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36744 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Year Laura Hartman 10 2:15 PM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3701 International Drive Apt 645 Silver Spring Montgomery 6. Sex 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 □ M 2 🖾 F Hours York, PA 0976871924 87 196-18-7266 **Director** Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 A Yes 2 No MD Montgomery Silver Spring 10e, Street and Number 10f. Zip Code ö 10g. Citizen of What Country? iral", or items 23a or Examiner must be i Funeral 3701 International Drive, Apt. 645 20906 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Nidowed 4 Divorced White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Homemaker Own Home ath and Mental Hygier of is marked other ter traumatic event, the Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Page 1 and 2 should be filt Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve မ Leslie E. Lind Orpha Mae Bostian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brookeside Road, Berlin, Maryland 21811 Joan Chesser 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 X Removal from State cemetery, crematory or other place) Manchester Union Cem. 11/15/2011 Manchester, PA. 17345 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee MO0696 Diehl Funeral Home, Box 1031, Mt. Wolf, Pa. 17347 uhan 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Years Immediate Cause (Final Physician/ Congestive Heart Failure disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury burial-tran that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☒ No for Month Day Year Pregnant at time of death signed by the a d be detached for g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? Atrial Fibrillation 24a. Was an this certificate has page 2 autopsy performed? Yes 2 No 1 Yes 2 No ie Hospine. in 24 hours after death. the Funeral Director. After this certificate the Funeral director, ps 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 🗷 Nursing Home 5 🗆 Residence 6 🗀 Other (Specify) Hospital 1 🗌 Yes 2 X No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 \square Pending work?
1 \(\subseteq \text{ Yes} \quad 2 \subseteq \text{ No} \) Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Exam sis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 To the F 3 Certifying Wurse ractioner: o the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29d. Date signed (Month. Day, Year) November 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

3801 International Dr., # 211, Silver Spring, MD 20906

PA.

M/D.

Nakul Coyal,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 30 per dvr g921 11-17-11 vt
State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 31, 201^{Year} 7:00 AM M Medical Twyla Marie Johnson 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 603 S. Grundy Street If Under 1 Year If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** . Age (In yrs. last birthday) 8. Date of Birth Feb 12, Year) 1919 West Virginia 234-28-8960 **Director** 1 □ M 2 🗓 F 92 Yrs. Usual Residence of Decede or 28a-f show 10a. State at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f si traumatic event, the Medical Examiner must be notified 1 X Yes 2 □ No MD Baltimore 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? by Funeral 21224 USA 603 S. Grundy Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4 or 5+) own home homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Okey Oralie Meadows Cecil Edgar Shires 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
4414 Meadowcliff Road Glen Arm. MD 21057 permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other tra Jean E. Prevas/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 Other (Specify) Director censee State Andtomy Board 655 W. Baltimore Street S mm. MDBaltimore, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Ph sician/ ADVILLAM Medical resulting in death) Due to (or as a consequence of): Examiner Due to (or as a consequence of): Se wentially list conditions if any, leading to immediate cause. Enter Underlying Examiner sician and burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Day Month Year ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Dimaris 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed Yes 2 2 🗌 No 1 🗌 Yes funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Hospital: 1 🗌 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral di 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Examiner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the I Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifler 29d. Date signed (Month, Day, Year) 024276 11. 7 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Simon Scalia 2801 Hudson St. Baltimore, Md. 21224

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Johnson I Month 2011 :20 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 5. Social Security Number 9. Birthplace (State or Fpreign . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 1 MM 2 DF Months Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Funeral Director 1 Nes 2 No Marylan ö 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Moravia 3323 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Matus 14, Race - American Indian traumatic event, the Medical Examiner Black, White, etc. ò 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☑ No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ unknown Johnson Stephanie Page 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type, Print) 607 item 27 Keyonna Christian tentland Urive 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o Burial 2 Cremation 3 Removal from State orraine 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a, Part 1, Enter the disea or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immedia e Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Day Year cate has been signed by the a page 2 should be detached f Yes 2 No 1 U Yes 2 L 9 Unknown 11 -14-2011 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 5 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 XN Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Npatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1. Natural Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Geriffying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29d. Date signed (Month, Day, Year) wan of person who completed cause of death (Item 23a) (Type, Print) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per INF G922 12/13/2011 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 15, 9:07 PM Rochelle Elizabeth Jacobs 2011 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Center for Hospice Care Towson Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Jul 22, 1976 35 218-86-6583 **Director** 1 M 2 F Maryland Usual Residence of Decedent 28a-f shov 10a. State must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Baltimore 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 5009 Frankford Avenue 21206 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. ö þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. "natural", 3 Widowed 4 Divorced Specify: Completed White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Waitress should be filed with and Mental Hygier 7 is marked other t Hospitality Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ben Franklin Jacobs, Sr. Frances Louise Fauble Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print)

Joshua Jacobs /Son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8021 Bank Street Baltimore, MD 21224 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Nov 17 1 Burial 2 Cremation 3 Removal from State Beltsville, Maryland Chesapeake Crematory 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final hysician/ FALL WITH TRAUMATIC BRAIN disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner CERTIFICATION NAMED BY MEDICAL EXAMINES Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 the 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) ding IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box (in the past 12 mont Month Dav Year 9 Unknown g Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð OSTEO MYELITIS Division of Vital Records, 1 Yes 2 No 3 Probably 4 Onknown Completed GASTROINTESTIWAL BLEED 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an ALGOHOUSM performe 1 Yes 25. Was cas eferred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending iniury 1112007 1 Yes 2 No dub ject unknou4 M Director: / Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number ate) Town MD Len lastuses Drive determined building etc. (Specify) 5717 Garden Pastures -Home Hospital 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 29b. Signature and title of certifier 29c. License number DETH CHARLES State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36748 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HAROLD NOVE MB4 Day 1:00 PM 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death NORTHWEST HOSFITAL PANDAUS OWN BALTIMORE Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Month, Day, 1 X M 2 - F Months Days Maryland Director 216-16-8005 June Usual Residence of Decedent items 23a or 28a-f show her must be notified at 10a, State 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** Baltimore 1 Yes 2 X No Pikesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 725 Mt. Wilson Lane 21208 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, er than "natural", or ite the Medical Examiner Armed Forces? Black White etc. ģ 1 Never Married 2 Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) education 8 principal 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H f item 27 is marked ot r other traumatic ever မ Mary Levenson Morris Katz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6931 Tolling Bells Ct; Columbia, MD 21044 Department of Health ar Important: If item 27 is any injury or other trau Johnathan Katz - son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 M Donation 5 Other (Specify) of Funeral Se RONA 22. Name and Address of Facility State Anatomy Board Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the interest of the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIO VASCULAR Physician/ ATHUROSCLEROTIC disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month ☐ Pregnant at time of death☐ Unknown 5 Other (specify) Dav Year signed by the a d be detached for 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 bours after death.

To the Funeral Director. After this certificate has completed filler in by the funeral director, page 2. performe 2 M No 1 Tyes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 🗌 Inpatient 2 🗹 ER/Outpatient 3 DOA Certificate: 27. Man er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No Investigation Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Gertifying Nume Frantionen To the best of my knowledge, death. 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RADALLSTONN MARYLAND ROTHKIN 5401 OLD COURT 31. Date filed (Month.

DHMH 17 Rev 7/2009

Registrar

Registrar
DHMH 17 Rev 1/2001

State

Grantsville, Md. 21536

124 Miller Street

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32

Robin Lee Bissell

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November November ,2011 Charles E. Keiger 11:20A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Gilchrist Hospice Towson Baltimore Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** . Age (In yrs. last birthday, 302-09-1687 1 🛛 M 2 □ F Ohio Director 81 Nov. 29,1929 Usual Residence of Dec 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland imment of Health and Mental Hyglene.
 Itant: If items 23a or 28a-f sho tant: If item 25a or 28a-f sho irry or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, 10a. State 10c. City, Town or Location 10d. Inside City Limits s 23a or zo... must be notified a' **Funeral Director** Ohio Hamilton Cincinnati 1 Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 8886 Balboa Drive 45231 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. by 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) Self-Employed Sign Painter Be 17. Father's Name (First, Middle, Last)
James Keiger 18. Mother's Name (First, Middle, Malden Surname) 9 Lelia Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dale Keiger 13 Norris Run Court, Reisterstown, Maryland 21136 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important; If ite any injury or ot once. ArlingtonMemorialGardens 11-17-11 Cincinnati, Ohio Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. michai 6009 Harford Road, Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examine Due to for as a sone squeries of y. cause. Enter Underlying Cause (Disease or injury the attending physician and thed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: page 2 should be detached for use 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregna5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: performed 1 Yes 2 No disease 25. Was case referred to medical Be 26. Pls e of Death (Check only one) Other: 1 Ves 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA Horspi co 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 ☐ Natural 2 ☑ Accident 5 Pending Investigation 4.30 PM out 01 Suicide 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and None or or Rural Route Number, City or Town, State) 13 Novin Peur Court, determined building, etc. (Specify) Cherry 103-1 Medical Certifying Physician: To the best of my knowledge, death occurred at the trie, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only one) Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) MD 71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

ARATHI

filed (Month, Day, Year)

NOV 1 7 2011

N CHARLES

QUITE 4105 RAITEMORE

6701

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 1 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Felice Lombardo 205 AM 16 2011 11 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Square Hospital Center Rosedale Baltimore 8. Date of Birth (Month, Day, Dec. 19, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Hours Min. Brooklyn, NY Director 218-12-4088 87 Usual Residence of Decedent the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits T is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at Director 1 ☐ Yes 2 No MD Baltimore Nottingham 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 4020 Klausmier Road 21236 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12 Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 Never Married 2 Married 21215-0036 1 ☐Yes 2X No Specify: Completed by Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Construction Elementary/Secondary (0-12) College (1-4or 5+) Contractor Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental Felice Lombardo Baiata Giovanna 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 is
any Injury or other trau 4020 Klaumier Road Nottingham, MD 21236 Anna Lombardo/ Wife Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of November 16, cometer, crematory or other place)
Evans Funeral
Chapel – Bel Air 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, MD 2011 21. Signature of Funeral Service License 22 Name and Address of Facility Chapel & Cremation Services 8800 Harford Rd. Parkville, MD 21234 2 a. P. tt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hourt failure. List only one cause on each line. slock, or hart failu iate Cause (Final disease or condition **Physician** a. Heute non-st elevation myocardial infarction /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician and s the burial-trans Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ed by the a 1 □Yes 2 □No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Onknown Completed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

requires that the death certificate be executed Division of Vital Records. P.O. Box 68760. cate has been signed by page 2 should be detach certificate has or Attending Physician: funeral director, After this

barr

24 hours a

Be

Certification: To

Medical

25. Was case referred to medical examiner?

5 Pending investigation

6 ☐ Could not be

1 Yes 2 No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

31. Date filed (Mont

29a, Certifier

4 Homicide

Hospital: 1 Inpatient

28a. Date of Injury (Month, Day, Year)

To the I within 2 54

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) 11-16-2011 D72364 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sarwate FRANKLIN Devadatta A Balto Square DR 21237

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No

24a Was an

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy performed?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar 2 ER/Outpatient 3 DOA

28b. Time of

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 per me,g921,11/17/2011dhb.
Certificate of Death
Reg. No. 1 - State Registrar 2. Date of Death 3. Time of Death Physician/ Month Medical ty Name (if not institution, give street **Examiner** Town, or Location of Death 4b. City, County of Death ARREI Elotminste If Under 1 Year If Under 24 Hrs. Age (In yrs. last birthday) 8. Date of Birth
(Month, Day, Yes
June 4, 9. Birthplace (State or Foreign **Funeral** Months Min Director 215-32-5437 Massachusetts Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2 No MD Carrol1 <u>Hampstead</u> 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 1811 Albert Rill Road 21074 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white Completed 3 Widowed 4 X Divorced Specify. and Mental Hygiene.

is marked other than "naturraumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) own home 0 homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ruth McBride McHaffie George Henry Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6525 Plaid Place Colorado Springs, CO 80918 Lynn Hook/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 X Donation 5 Other (Specify) 22 Name and Address of Facility State Anatomy Board 655 W. Baltimore Street MD Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, of heart failure. List only one cause on each line. Approximate Interval Between shock, of Immediate Cause (Final Onset and Death Ph, sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months
1 Yes 2 HO Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 1 Yes 2 100 3 Probably 4 Unknown 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of within 24 hours after death.

To the Funeral Director, After this certificate has performe death? Yes 2 L Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospita 1 ☐ Yes 2 🕱 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred the Hospital or Attending thin 24 hours after death. (Month, Day, Year) Natural 5 Pending work' Accident Investigation 1 Tes 2 🗌 No Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifie Lertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one of person who completed cause of death (Item 23a) (Type, Print) Males Im dure ANERR

State

Registrar

32/Registrar's Signature

7

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011

			State Registrar 1. Decedent's Name		State of			rtificate				2. Date of De	Reg. N			3675
	Physicia Medic	al			Rosi	na A. Lui	by					Month Novembe	r 14.	2011	Year	3:00 A
	Examin	er	4a. Facility Name (if Stella Mar:	is	give street and nun	nber)		Timo	nium	Location (4	Baltim	f Death ore	
	Funeral Director		5. Social Security No. 216–16–698. Usual Residence of	3	5. Sex 1 □ M 2√√√ F	7. Age (In yrs.	. last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, Da December	th ay, Year, 7 ,.	1923	9. Birthp Count MD	lace (State or Foreig ry)
	Maryland 28a-f show atified at	rector	10a. State MD	10b. County N/A			city, Town or Lo altimore	cation							1	0d. Inside City Limits XX Yes 2 □ N
	with the s 23a or 2	Funeral Director	10e. Street and Nun 3838 Rolan		#1111			10f. Zip	Code 212	11			10g. (U.S.	nat Coun A.	try?
980	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		11. Marital Status 1		Armed Fo	XX No		Was Deced If Yes, spec 1 Yes	fy Cuba	n, Mexicar	n, Puerto	cify Yes or No Rican, etc.)	-	14. Race Black Specify:	, White, e	etc.
21215-0036	rithin 72 hou lene. r than "natu the Medical	Completed by	(Spe	15. Decedent ecify only highest ondary (0-12)	s Education grade completed, College (1	-	(Give	dent's Usua kind of wor O NOT use aker	k done a	ation luring mos	t of worki	ing	I	Kind of Bus		dustry
Maryland 2	d be filed w Mental Hygi arked other itic event, i	l as b	17. Father's Name (I	First, Middle, La	st)							e (First, Middle Panibianc		n Surname)		
, Man	nd 2 should salth and N n 27 is ma		19a. Informant's Na Karen Kunk				19b. Maili 997 S	ng Address t. Mar	(Street a garet	nd Numbe s Driv	er or Rura r e Ann	apolis,	er, City MD	or Town, Sta 21409	ate, Zip C	'ode)
Baltimore,	Page 1 arment of He tant: If iter ury or oth		20a. Method of Disp Warrial 2 4 Donation		B ☐ Removal from	Ciaia	Place of Dispo cemetery, crer y Redeem	natory or o	her plac	e)	11/17	Date 1/11	20c.	Baltin		
Balt	permit. Depart Import any inj once.		21. Signature of Fur	neral Service	eper l	1	Hu 36	2. Name and rg ee 11 6 31 Fa1	Addres	sof Facilit Seitz ad Ba	Funer	al Home, MD 2121	Inc 1			
-	Physician/ Medical Examiner		23a. Part 1. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	rt failure. List on Final	ly one cause on ea	caused the deach line. Gach cance Cance Cor as a conse	R	er the mode	of dying	g, such as	cardiac c	or respiratory a	rrest,			Approximate Interval Between Onset and Death
0	be executed sician and burial-transit	ical Examiner	Sequentially list co if any, leading to in cause. Enter Under Cause (Disease or that initiated events resulting in death) I	injury S	c	(or as a conse		,								
. Box 68760	Attending Physician: The law requires that the death certificate be executed or death. ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ∑ 9 ☐ Unknown	months?		Birth 2 ☐ Fe Inant at time o	etal death 3	☐ Ectopic p		у				23d. Date Mon		ery Day Year
s, P.O.	ires that th signed by Id be detac	d by Ph	Part II. Other signif	icant condition	s contributing to d	eath but not re	esulting in the u	underlying o	ause giv	en in Part	I.					e cause of death?
Records,	sician: The law requ certificate has beer lirector, page 2 shou	Completed by										24a. Was auto perf 1 \(\sum \) Yes	opsy ormed?	pr de	ere autorior to coneath?	osy findings availab impletion of cause o
Vital	certifica rector, I	Be	25. Was case referre		Hospital:				Othe	\p.		(only one)				
on of V	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director, After this certific completely filled in by the funeral director.	Certificate: To	1 ☐ Yes 2 ∑ 27, Manner of Death 1 X Natural 2 ☐ Accident	_	28a. Date (Mon	Inpatient 2 L of injury th, Day, Year)	28b. Time of injury		Bc. Injury work	4 □ Ni at		me 5 Res 28d. Describe				HOSPICE
Division	는 를 를 드		3 Suicide 4 Homicide	6 Could no determin	28e. Place	of Injury - At I ng, etc. (Spec	home, farm, str ify)	eet, factory	office			28f. Location City or To			or Rural	Route Number,
	To the Hospital or within 24 hours after To the Funeral Director completely filled in	Medical	(Check 2 only one) 3	Medical Ex	Physician: To the baseminer: On the baselurse Practitioner	sis of examinati	ion and/or inves	tigation, in r	ny opinio rred at t	n, death o he time, da	ccurred at	the time, date	and pla	ce, and due	to the cal	use(s) and manner sta
	To t Vith Court		29b. Signature and	Ma	ear	DNP,	NP		_	number 305	778	2	29d. [Date signed	(Month, 1	2011
	1		30. Name and addre	ess of person wi		se of death (Ite										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36754 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year 1110 A JOHN MARSHALL November 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Dorchester General Hospita Cambridge Dorchester Social Security Number If Under 1 Year | IPUnder 24 Hrs. Birthplace (State or Foreign Country)unk 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Jan 15, 1 X M 2 🗆 F Days Hours Ϋ́Τ̈́960 **Director** 51 219-70-8286 Usual Residence of Decedent items 23a or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 🗆 Yes 2 🔀 No MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 5002 Maple Dam Rd. 21613 12. Was Decedent Ever in U.S.UNK 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces?
If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk Race - American Indian. Black, White, etc. o 1 Never Married 2 Married þ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white If Yes, Give "natural", Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation uni (Give kind of work done during most of working life. DO NOT use retired) injury or other traumatic event, the Medical 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) unk unk arshall , John Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5002 Maple Dam Rd; Cambridge, MD 21613 Ralph Hall - cousin 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) In State cemetery, crematory or other place 22. Name and Address of Facility State Anatomy Poard tu of Funeral Service rector 655 W. Baltimore St; Baltimore, MD 21201 Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DISEASE OPONARY TERY disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner DISEASE CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the attending physician and hed for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 4 Pregnant Month Pregnant at time of death 5 Other (specify) 2 No ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed director, page 2 should 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performe death? 2 No 2 - N Be 25. Was case referred to medical 26. Place of Death (Check only one)

Division of Vital Records, P.O. Box 68760 Physician: The law requires certificate this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral To the Hospital or Attending

> 30. Name and a ress of person who completed cause of death (Item 23a) (Type, Print) BYRN 503 31. Date filed (Month, Day, Year) State NOV 1 Registrar

5 Pending

Investigation 6 Could not be

examiner?

27. Manner of Deat

1, 🖺 Natural

29a. Certifier

(Check

only one)

29b. Signature and title of certifier

Accident

Suicide

မ

Certificate:

Medical

2 No

1 🗌 Inpatient 2 ಿ ER/Outpatient 3 🗌 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

28b. Time of

28c. Injury at

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

STREET

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

work? 1 🔲 Yes

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

D69234

29c. License number

2 🔲 No

CAMBRIDGE

28a. Date of injury (Month, Day, Year)

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

MARYLAND

2011

21613

11-08350 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. James Robert Scott Markley State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar

1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ November 7, 2011 1215 hrs Medical Examiner James Robert Scott Markley 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 436 Homer Street Cumberland Allegany 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign West 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) If Under 24Hrs. **Funeral** Months Days Hours Director Country)Virginia 212-38-6597 1 X M 2 F Jan 14, 69 Yrs 1942 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. Allegany MD Cumberland Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Montal Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28s-f sho
iujury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21502 436 Homer Street Funeral 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes Specify: white 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Þ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) school custodian 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) BB David Franklin Markley Sr. Emma Frances Bray 19a. Informant's Name/Relationship (Type, Print) r 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 436 Homer St; Cumberland, MD 21502 Rita Markley - wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 22. Name and Address of Facility State Anatomy Board Signature of Experal Service Licer Ronald S rector W. Baltimore St; Baltimore, MD 21201 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on each line Between Onset and **rMedical** a, Hypertensive Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate has been signed by the attending physician and ector, page 2 should be detached for use as the burial - transit cal UNPENDED AMENDED Physician/Medi IF FFMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy Was decedent pregnant in the Live birth 3 Ectopic pregnancy 2 Fetal death Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 ✔ Unknown Chronic Alcoholism Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 No ✓ Yes director, 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other | Nursing Home 5 Residence 6 Other: Scene this ✓ Yes 2 No After the 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 1 V Natural Pending 1 Yes 2 No the 2 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State)

Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: completely

28f. Location (Street and Number or Rural Route Number, City Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) O.C.M.E November 8, 2011 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 Ling Li, MD 31. Date filed (Month **ORIGINAL OCME**

Death

Year

cal

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 10 Vembe Physician/ Bernice Lena Morgan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Glen Burnie Baltimore Washington Medical Center 8. Date of Birth Jan 30, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** ^{Year)}932 Maryland Director 79 216-28-7120 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits the Maryland Examiner must be notified at Director 1 Yes 2 No 28a-f Glen Burnie MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Funeral 23a 7355 E. Furnace Branch Rd. 21060 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 0 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 🛛 No Specify: Specify: "natural", 3 X Widowed 4 ☐ Divorced Year or Dates 27 is marked other than "natur traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) cosmetology cosmetologist 8 permit. Page 1 and 2 should be filed wil Department of Health and Mental Hygie Important: If item 27 is marked other any Injury or other traumatic event, #1 once. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edna Lulie Michael Quasney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24 Chesapeake Mobile Ct; Hanover, PA 21076 19a. Informant's Name/Relationship (Type, Print) Valerie Man - POA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board uneral Ser 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical s a consequence of **Examiner** Sequentially list conditions, Examine If any, leading to in media cause. Enter Underlying so the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury the burial-trans and that initiated events resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Por Month Dav 5 Other (specify) Pregnant at time of death the a Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 s has certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Certificate: To Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1-P Inpatient 2 - ER/Outpatient 3 - DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral di funeral 28a. Date of injury (Month, Day, Year) 27. Manner of De th 1 Natural 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 5 Pending Accident Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie ovembe cause of death (Item 23a) (Type, Print) DRIVE SumE, MD , 2/06/ State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death ecedent's Name (First, Middle_Last) 2. Date of Death 3. Time of Death Physician/ 4.00A.M Medical acility Name (if not institution, give street and nu or Location of Death 4c. Gounty of Death **Examiner** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign (In yrs. last birthday) **Funeral** Hours 1 M 2 D F Days Director 28a-f shov 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified Yes 2 □ No MD Street and Numb ö 10e 10f. Zip Code 10g. Citizen of What Country? ms 23a or 628 1154 121 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, the Medical Examiner Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. ò þ Baltimore, Maryland 21215-0036 1 Yes 2 No "natural" 3 Widowed 4 Divorced Specify: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DQ NOT use retired) Il Hygiene. College (1-4 or 5+) Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ . Informant's Name/Relationship (Typ , Print) or Rural Route Number, City or Town, State, Zip Code) 110 20a. Method of Disposition 20b. Place of Disposition (Name of 1 Burial 2 Cremation 3 Removal from State cemetery, cramatory or other place 4 ☐ Donation 5 ☐ Other (Specify) NOV.15,2011 permit. 270 Fredhilton Pass Baytomb 21229 ner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest heart failure. List only one cause on each line. 23a. Pak 1 Approximate Interval Between Immediate Cause (Final Onset and Death Rhysician/ RENAL END STAGE disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examir attending physician and for use as the burial-transit POLY SUPFOTANCE Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be exithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FEMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death Month Dav Year signed by the at Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed plnods 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed Yes 2 page 2 death? 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) ျှ 1 Tyes 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 201 East University Parkany 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. for State Registrar State of Maryland / Department of Health and Mental Hygiene 36758 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 730 A M The mos E - McVicker

4a. Facility Name (if not institution, give street and number) Month Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore, Maryland Charles hown Care Center Baltmore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral Hours Min. (Month, Day, Year) 1**X** M 2 □ F 484-07-0313 **Director** 96 Yrs 1915 Towa Usual Residence of Decedent or 28a-f show notified at 10b. County hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Catonsville Baltimore Maryland

10e. Street and Number ō 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral United States 717 Maiden Choice Lane #315 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼Yes 2 □ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: WHITE Completed 3
Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other that amy injury or other traumatic event, the long. 4 years Mechanical Engineer Private INdustry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Virginia Constant James R. McVicker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 717 Maiden Choice Lane #315, Catonsville, MD 21228 <u>Margaret McVicker - WIFE</u> 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC 11-17-2011 Baltimore Maryland rignature o Funeral Service Licensee 22. Name and Address of Facility Cremation Society Of Maryland INC 299 Frederick Road, Baltimore Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Bacterial endocarditis Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 Yes 2 No Day 5 Other (specify) Month Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Diabetes mellity 5 with repel complications 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has funeral director, page 2 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: Nursing Home 5 - Residence 6 - Other (Specify) Hospital: 1 ☐ Yes 20 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred injury 1c Natural 5 Pending 2 Accident 3 Suicide Investigation within 24 hours are decit To the Funeral Director of completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) Jan M. Butterworth CKNP 11-16-2011 R082382 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ann Butternoth, cano 709 Maidenche u La Balto, Md 21228

State Registrar 31. Date filed (Month, Day, Year) NOV 1 7 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#18perFH,G921,11/17/2011,WS
State of Maryland / Department of Health and Mental Hygiene For State Registrar 36759 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 5:15 PM M 2011 <u>Elizabeth Louise Mansfield</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 11945 Jerusalem Road Kingsville Year If Under 24 Hrs.
Davs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 **Funeral** Months Days Director 215-30-0792 Usual Residence of Decede 1 🗆 M 2 💢 F 02/07/1934 Maryland 77 show. 10a. State ms 23a or 28a-f shorms must be notified at 10b. County 10c. City, Town or Location Director 1 Yes 2X No MD Baltimore Kingsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 11945 Jerusalem Road 21087 U.S.A items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 No Black, White, etc. ö þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Exami Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3 X Widowed 4 Divorced White Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Mergenthaler Elementary/Secondary (0-12) College (1-4 or 5+) Technical Institute 12 Teacher Be 8 Mother's Name (First, Middle, Maiden Surmarne) **Elizabeth Gertrude Ruggli** 17. Father's Name (First, Middle, Last) ဂ္ William Fred Miller Certrude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann E. Moellman (daughter) 12031 Moonlite Lane - Stewartstown, PA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 11/21/2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. <u> 11750 Belair Road - Kingsville, Maryland</u> 21087 as 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 Ph_sician/ Non LIN disease or condition Medical resulting in death) Due to (or as a consequence f): Examiner Sequentially list conditions, Examine Due to (or as a consequence of) If any, leading to immedicause. Enter Underlying attending physician and for use as the burial-transi Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Other (specify) Pregnant at time of death is certificate has been signed by the a director, page 2 should be detached g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 ☐ No Hospital: Other: ဂ္ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pending Investigation Accident 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the F only o 29b. Signat 29d. Date signed (Month, Day, Year) 045390 November 14 2011 person who completed cause of death (Item 23a) (Type, Print) Road # 208, Beltimore, MD 21237 101 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 8,26 per fh/dr., e921,11/17/2011dhb

Reg. No 1 - For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Mackel Davald D 01:46 AM 2011 Medical 4a. Facility Name (if not institution, give street and number)
University of Maryland Medical Contr 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimen, MD 8. Date of Birth 10/24/1955. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** M 2 🗆 Director 28a-f show 10b. Count 10a. State City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Ves 2 No 10e. Street and Number 10g. Citizen of What Country? ö Funeral items 23a USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Desedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armo Fo Forces? Black, White, etc ō ģ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates "natural", 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working Il Hygiene. ife. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) hincian and Mental Hygie is marked other Be 17 Father's Name (First Middle Last ည permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is mark 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Numbe injury or other Baltimore, d of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) any 8728 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final. Ph_sician/ Pleunl effusions disease or condition Medical resulting in death) **Examiner** 2 years - Myclogerous Sequentially list conditions Examine If any leading to this nectal cause. Enter Underlying that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and burial-trar Due to (or as a consequence of). nding physician use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ò Pregnant at time of death 5 Other (specify) Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Records, 1 Yes 2 No 3 Probably 4 thinknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an page 2 performed certificate Yes 2 No Division of Vital 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) 1 🗌 Yes 2 UNO မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 20 136676782 11/6/2011 M.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Sanam Parshi Mb, 22 S. Green Ct,

Registrar

(Month, Day, Year)

NOV 1 7 2011

Jarka

/32. Registrar's Signature

Baltimore, MD

21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month 10:25 P M KOXIE FULTON MCFADDEN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A HOSPITAL BALTIMORE MARBOR Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 M 2 MF **Director** SC 212-24-8388 92 Feb 1, 1919 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b County with the Maryland at 10c, City, Town or Location Director ral", or items 23a or 28a-f s Examiner must be notified 1 Xes 2 No **Baltimore** MD Anne Arundel 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code Funeral 1005 Veronica Avenue 21225 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 hours after 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify. Black "natural", Completed 3 XWidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 721 th and Mental Hygiene.
77 is marked other than traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Hotel Hospitality 12 Be permit. Page 1 and 2 should be fille.
Department of Health and Mental Humportant; if item 27 is marrany injury or other filed 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) ည **Preston Adams** Allean Fulton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1005 Veronica Avenue Baltimore, MD 21225 Tomika McFadden 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 1 XBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) Nov 20, 2011 Olanta, SC 4 ☐ Donation 5 ☐ Other (Specify) **New McFadden Cemetery** 21. Signature of uneral Service Lic-22. Name and Address of Facility Estep Brothers Funeral Service, P. A 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ BUADDER CANCER WITH LIVER disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Month Dav 5 Other (specify) signed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tohacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Nunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy page performed 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes မ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined

within 24 hours after death.

To the Funeral Director: Aft completed filled in by the fur

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUTH HANDLER STREET, BALTIMORE, MARYLAND, 21225 PATEL, 32. Registrar's signatur

modely, MD

DHMH 17 Rev 7/2009

Registrar

Medical

29a. Certifier

(Check

29b. Signature and title of certifier

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

RES OOI

NOVEMBER 12, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36762 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November Physician/ ANNIE MORRIS Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE DOCTORS COMMUNITY HOSPITAL GEORGE'S ANHAM If Under 1 Year 8. Date of Birth 7. Age (In vrs. last birthdav) If Under 24 9. Birthplace (State or Foreign Social Security Number **Funeral** 1 M 2 F Months Hours Min **Director** 1919 249 - 38 - 2458 Jun ems 23a or 28a-f show r must be notified at 28a-f show 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits with the Maryland Director 1 X Yes 2 No Md. Prince George's Upper Marlboro 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 10818 Sugar Maple Terrace 20774 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian 11 Marital Status the Medical Examiner Black, White, etc. 1 Never Married 2 Married þ permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed Black 3 XWidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Domestic 6th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Nathaniel House, Sr Annie Greene 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sugar Maple Terrace Upper Marlhoro, Md Carol Kosh / Daughter 1081820a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Lincoln Cem 11-21-11 Brentwood, Md 22. Name and Address of FacilityCapitol Mortuary, Inc. e of Funeral Servic 1425 Maryland Ave. NE 20002 complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. 23a. Part 1. Enter the diseas shock, or heart failure. Approximate Interval Between Onset and Death nJerchion Immediate Cause (Final Myocardian Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to hours after death.

Funeral Director: After this certificate has been signed by the attending physicis. P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Pregnant at time of death signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 2. No 3 Probably 4 Unknown 1 🗌 Yes Completed been si 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 s autopsy performe 1 Yes 2 No **Division of Vital** 25. Was case referred to medica funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) þ 1 Tes 2 No I Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one

State Registrar 29b. Signature and title of ertifie

31. Date filed (Month, Day, Year)

NOV

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

500d

32. Registrar's Signature

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36763 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month ovembro Physician/ JOHN CLYDE NOLAN 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S DOCTORS HOSPITAL LANHAM If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Funeral Months Hours AUGUST AUGUST 1942 WASHINGTON, DC Director 69 579-54-7929 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location notified at Director 1 Yes 2 No PRINCE GEORGE'S UPPER MARLBORO MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Examiner must be 23a Funeral USA 14113 SILVER TEAL WAY 20774 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ŏ 1 Never Married 2 XMarried δ Maryland 21215-0036 BLACK 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 9TH BUS OPERATOR PRIVATE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 EFFIE LEE JOHN JACOB NOLAN permit. Page 1 and 2 should be Department of Health and Meni Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14113 SILVER TEAL WAY UPPER MARLBORO, MARYLAND 20774 OLIVIA L. NOLAN/WIFE Baltimore, 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State RESURRECTION CEMETERY 11/19/2011 CLINTON, MARYLAND 4 Donation 5 Other (Specify) 22. Name and Address of Facility J. B. JENKINS FUNERAL ROME, INC. 21. Signature of Funeral Service Licenses 7474 LANDOVER ROAD HYATTSVILLE, MARYLAND 20785 23a. Part 1. Exter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of hear/fallure. List only one cause on each line.

Immediate dause (final disease or condition and the such as a family as a family and the such as a family and the such as a family and the such as a family as a family as a family and the such as a family as a fam Interval Between Onset and Death Ph_sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter organizing Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last and-trar Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Pregnant at time of death the g Unknown P.O. ed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e, Did tobacco use contribute to the cause of death? signed I by Records, 1 Yes 2 M No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? this certificate has ral director, page 2: death?
1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) _2 🔽 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work? 1 \square Yes 2 \square No 27. Manner of Death 28b. Time of n 24 hours after death. ne Funeral Director: After the pleted filled in by the funeral Certificate: 28d. Describe how injury occurred 1 Natural iniury 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 2 3 [29b. Signature and titl 29d. Date signed (Month, Day, Year)

State Registrar

V

Good Lack

MO 20706

30. Name and address of person who completed cause of death (Item 23a), (Type, Print)

Year)

8118

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last 2 Date of Death Nicholson Mary Physician/ Month 1022 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Howard County General Hospital Columbia Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 8 Date of Birth 7. Age (In vrs. last birthday) **Funeral** Days Hours (Month, Day, Year) Months 217-22-6155 **Director** 1 □ M 2 🛚 F 85 May 1, 1926 Illinois Usual Residence of Decedent 10a. State 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits notified at Director 28a-f 1 X Yes 2 No MD Montgomery Burtonsville 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 16114 Old Columbia Pike 20866 U.S.A. items death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Armed Forces? Black, White, etc. ö þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify Specify: White 3 ¥ Widowed 4 ☐ Divorced "natural" Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Home maker Own Home other ulth and Mental Hygie 27 is marked other r traumatic event, ti Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ John Herbert Wilkerson Mona Winnie Sisk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health aitem 27 11500 Brundidge Terr., Germantown, Maryland 20876 Dorothy J. Sandstrom /daughter other t 20a. Method of Disposition 20b. Place of Disposition (Name of : of F Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State Department of Important: If any injury or Meadowridge Mem Pk Nov 17, 11 Dorsey, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22 Name and Address of Facility
Donaldson Funeral Home, P.A.
313 Talbott Ave., Laurel, Maryland 20707-4389 M00773 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ bladder cancer disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter a denying Cause (Disease or injury that initiated events Due to (or as a consequence of) the burial-trar and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? jo Month Day Year Pregnant at time of death signed by the at d be detached for 1 Yes 2 S Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ in fore my ocardia 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has page 2 autopsy performed death? To the Hospital or Attending Physician; The within 24 hours after death.

To the Funeral Director; After this certificate I Yes 2 K 1 Yes 2 400 funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ည 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a

To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 N. M.D. 00066 [1] Nov 13 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johns Hopkins Community Physicians 5755 Cedar Lane Columbia, MD

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year

arka

32. Registrar's Signature

Please Type or Print in Black Indelible Ink 15 per ME No Print in Black Indelible Ink 15 per ME No State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death Day 2 Physician/ Month Year Irwin Okedas 17:35 JOY Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A st. Agnes Hospital Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) Funeral Days Hours Min (Month, Day, Year) Jun 9, 1923 1 XM 2 🗆 PA 88 146-18-6581 Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Examiner must be notified at Director 1 Yes 2 No MD **Baltimore City Baltimore** 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a Funeral U.S.A. 21217 2712 Auchentoroly Terrace within 72 hours after death 12. Was Decedent Ever in U.S.
Armed Forces?

1 Xes 2 No 3/21/1956
If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ♣No Black Specify: Specify 3 Widowed 4 Divorced 1/27/196-Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Megonee. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) **Meat Cutter** A & P / Super Fresh 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Okedas **Emily Okedas** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5627 Belle Avenue Gwynn Oak, MD 21207 Gloria Martin 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Nov 29, 2011 Owings Mills, Md. **Garrison Forest Veterans** 4 Donation 5 Other (Specify) 21. Signature of Fameral Service License 22. Name and Address of Facility.
Estep Brothers Funeral Service, P. A.
1300 Eutaw Place Baltimore, Md 21217 Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Pulmon ary Physician disease or condition resulting in death) Embelis one ment Medical Due to (or as a consequence 1) Examiner Subcapital onement Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying CERTIFICATION APPROVED BY MEDILAL EXAMINER Cause (Disease or iinjury that initiated events resulting in death) Last - difficile and the burial-tran Due to (or as a consequence of): physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate bein 124 hours after death. Prey monia Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ for in the past 12 months? Day Month Year 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, the funeral director, page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autonsy performed? Yes 2 No 1 Yes 2 No Yes Division of Vital Be Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No 2 1 Inpatient 2 PER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify 28d Describe how injury occurred subject fell while bowling 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at injury ☐ Natural ☐ Adcident 5 Pending 1 Yes 2 1 No Un known M Investigation 10/17/2011 after death 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 24 hours a Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) PG1Y2 Resident P25483 11/12/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Priyaa Viswanathen, 900 Carton Avenue, Baltimore, MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Irwin.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 1 State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 - For State Registrar 36766 . Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month EVS Clyde 17:55 ovember 3,2011 Medical Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death nn rove 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign If Under 1 **Funeral** 478-36-4560 Month Min New Hampton, IA (Month, Day, Yea 5/3/1937 1 M 2 □ F **Director** 74 Usual Residence of Decedent with the Maryland notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f PA Franklin Fayetteville 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Count must be r 17222 USA Funeral 7033 Fairway Oaks items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, "natural", or iter edical Examiner Black, White, etc. ģ 1 Yes 2 No If Yes, Give Year or Dates. 1 Never Married 2 Married filed within 72 hours after 1 ☐ Yes 2 ☐ No Specify Maryland 21215-0036 Specify: White Completed 3 Widowed 4 Divorced the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) than Elementary/Seeondary (0-12) College (1-4 or 5+) and Mental Hygiene. Dept. of Defense Design Engineer Be 18. Mother's Name (First, Middle, Maiden Surname)
Donafred I. Richards 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic even Clyde A. Peters ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7033 Fairway Oaks Fayetteville, PA Beverly Peters - spouse Baltimore, 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20h. Place of Disposition (Name of 20c. Location - City or Town, State 11/9/2011 19406 cemetery, crematory or other place) King of Prussia, Pa 4 ☐ Donation 5 ☐ Other (Specify) Cremation Society of Pa 22. Name and Address of Facility Auer Cremation Services of Pa., Signature of Funeral Service Licensee Harrisburg, Pa 4100 Jonestown Road Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Physician/Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No ate has been signed by the a page 2 should be detached f g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate 2 No 1 Pes 2 \ \ No ours after death.

eral Director: After this certifical filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 Natural 2 🗌 No Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Kristerauseraus 30. Name and address of person who completed sause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 06-2011

State

KRISHNASWAM

2011

31. Date filed (Month, Day, Year)

NOV 17

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 7:30 a M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Reperc Case N/A Homusood Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 🗆 M 2 🔀 Days Months **Director** 4/20/1943 219-40-6460 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Baltimore N/A MD 1 X Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21231 1607 Mulliken Ct. within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 1 Yes 2 No If Yes, Give 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 No Specify. Black If Yes, Give Year or Dates 3 Widowed 4 Divorced Specify: Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A Housekeeping Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Florence Hines Page 1 and 2 should be filed thrent of Health and Mental H rtant: If item 27 is marked ot jury or other traumatic ever Charles A. Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21223 2226 Penrose Ave. Baltimore, Randolph Watson- Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State permit. Page Department of Important: If any injury or Randallstown, MD King Memorial Park 11/10/2011 Donation 5 Other (Specify) Sign ure of Funeral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North MD 21202 Baltimore, Ave. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between s ock, or heart failure. List only one cause on each nate Cause (Final Onset and Death Physician/ d sea/ e or condition r su ling in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and that initiated events resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 10 No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 X No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending work 2 🗌 No Investigation 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) C 131846 30. Name and address of person who completed cause of death (Item 23g) (Type, Print)
HELEN FINOKHIN CENT 2235 Smith and, Suit 203, Bathmare, MD 21209 HELEN HINOKHIN, 31. Date filed (Month, Day, Year) State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State Registrar	State of Ma	ryland			nt of H te of D		nd M		giene Reg. No.	711		36	768
ı	Physicia	ın/	1. Decedent's Name (First, Middle, Last)								2. Date of De Month	Day	¥ .	/ear	3. Time of	- 1
	Medic Examin		Austin L. Parson 4a. Facility Name (if not institution, give str				4b. City	, Town, or	Location of	Death	Novembe	$\overline{}$	1, 2 . County of	011 Death	2:30	р ^М
محاجد بديونا	/		Cherry Lane Nursi					ırel					rince			
	Funeral Director		213 20 3037	M 2 □ F		st birthday) 87 Yrs.	Months	Pr 1 Year Days	If Under 24 Hours		8. Date of Bir (Month, Da Jan 27	1924	4	9. Birthp Count	lace (State or try) MD	Foreign
	and show lat	ē	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Loc	ation							11	0d. Inside Cit	y Limits
	Maryl 28a-f otifie	Director	MD Prince Geo	rge	Laur	rel									1 X Yes	2 🗌 No
	vith the 23a or st be r	ralD	10e. Street and Number 9001 Cherry Lane	<u>.</u>			10f. Zi	p Code				10g. Cit	tizen of Wh	at Coun	try?	
	items	Funeral		2. Was Decedent Everage Armed Forces?	er in U.S		Vas Dece	dent of His	spanic Origin , Mexican, I		cify Yes or No-		14. Race -			
036	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	d by	1XXNever Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1XX Yes 2 ☐ N If Yes, Give Year or Dates.	0			2 X No		derio i	lloan, cto.,			White, e fric	can Ame	ericar
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pu	e filed v ntal Hyg ed othe event,	To Be	17. Father's Name (First, Middle, Last)								(First, Middle,	Maiden (Surname)			
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ž	nd 2 sh ealth ar n 27 is ier trau		Wayne L. Dorsey/ C		111		_				urel,			.o, <i>בוף</i> 0		1.1
nore	Page 1 alment of H ant: If itel ury or oth		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	ce	ace of Dispos	atory or	other place	9 1	Nov.	18,		ocation - C	•		
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any injury or once.		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee			outus N			s of Facility		ldson 1		timor ral H			
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~~ its	Physician/		shock, or heart failure. List only one Immediate Cause (Final disease or condition	cause on each line.								rest,		0	Approximate Interval Betw Onset and D	veen
	Medical Examiner		resulting in death)	Due to (or as a			cara	10 / 42	culai	D1.	эсивс			+	<u> </u>	1001
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3876	ertificat ding ph	/Mec	IF FEMALE:	c. If yes, outcome of	prognan	101										
30x	e attended for us	Physician/M	in the past 12 months? 1 Yes 2 No	1 Live Birth 2 4 Pregnant at t	Fetal	death 3	Ectopic Other (s		/			5000	23d. Date Montl		,	'ear
0	at the o		9 Unknown Part II. Other significant conditions conti	9 ∐ Unknown	not resu	ulting in the ur	nderlying	cause give	en in Part I.		23e Did to	abacco II	se contrib	ute to th	e cause of de	eath?
JS, F	uires th n signe uld be c	ed by	Alzheimers Disease												oably 4 🖺 l	
COLC	law req las bee	Completed									24a. Was	osy	pri	or to cor	osy findings a npletion of ca	
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Vita	ysicial is certi directo	To Be	avaminar?	spital:	t 2 🗆 E	ER/Outpatient	t 3 🗆 D	Othor	r: 4 X Nurs		o <i>nly</i> one) ne 5 🗆 Resid	dence 6	Other	(Specify)		
Division of Vital Records, P.O. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day,	2	28b. Time of injury		28c. Injury work?	at	2	8d. Describe h			ореспу		
Nisic	al or Attendir s after death. al Director: Af ed in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury building, etc. (- At hon Specify)	ne, farm, stre					28f. Location (S			or Rural	Route Numbr	er,
Ω	ospital hours a	edical (29a. Certifier 1 Certifying Physici	an: To the best of m	y knowle	dge, death o	ccured a	t the time,	date and pla	ace, and	due to the ca	use(s) an	id manner	as state	d.	
	the Hithin 24 the Formplets	Σ	(Check 2 ☐ Medical Examiner only one) 3 ☐ Certifying Nurse I	ractioner: To the be	est of my	knowledge, d	eath occu	my opinior irred at the c. License	time, date a	nd place	tne time, date a e, and due to th	e cause(s	s) and manr	ner as sta	ated.	iner stated.
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r	<i> </i> Stat	e	Syed A. Sadiq, MD 31. Date filed (Month, Day, Year)				Road	, Sui	te 20	18,	Laurel,	MD	2070	8		
	Registra	_	NOV 1 7 2011 Cen	32. Registyer's	Ma	W.										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death ecedent's Name (First, Middle, Last) Day Month Physician/ 00:15 2001 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Medical 8. Date of Birth 9. Birthplace (State or Foreign Sex 1 XM 2 □ F **Funeral** (Month, Day, Year) Country) Months 79 415-36-3170 Tenn Director /22/1932 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. teath an "matural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Yes 2 No Millersville MD Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21108 Funeral 437 Williamstowne Ct. USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Black <u>چ</u> 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Air Lines Air Craft Mech. 12th N/A 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) ည Laura Robinson Robert Reed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 437 Williamstowne Ct. Millersville, MD 21108 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Deloris Reed- Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State MD Arbutus Memorial Pk:11/18/2011 Halethorpe, 4 Donation 5 Other (Specify) March F/H 1101 E. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Baltimore, MD 21202 23a. Part 1. En er the disease, or complications of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between shock, or heart failure. List only one cau Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Cause (Disease or linjury signed by the attending physician and defacted for use as the burial-trans that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy

Live Birth 2 D Fetal death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy 3 Day Year in the past 12 months? Month Pregnant at time of death Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 🗌 Yes 2 🗌 No 3 🗐 Probably 4 🔀 Unknown Alzheimers completed filled in by the funeral director, page 2 should peen 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy After this certificate has performe 2 🕱 No 1 Tyes Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 - ER/Outpatient 3 - DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: injury 1 🔀 Natural 5 \square Pending М To the Hospital or Attendii within 24 hours after death. To the Funeral Director: At 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) d title of certifie 29b. Signatul address of person who completed cause of death (Item 23a) (Type, Print) Name and ledicine, 22 S. Green Street Baltimore MD 21201 Department nristian

State

Registrar

filed (Month, Day, Year)

NOV

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Consequence	Elle Robinson		STATE OF MARY I- For State Registrar			of Health a of Death	ina ivienta		eg. No. 20	11 3677
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and manner stated. 29b. Signature and title of certifier 29c. License number O.C.M.E. November 7, 2011 30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223	T the dear by the a ached fo	<u> </u>	9 0116		esulting in th	e underlying caus	e given in Part I	. 23e. Did to	obacco use contribute	e to the cause of death?
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Donna M. Vincenti, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223			D-70L-			0.0	C.M.E.		November 7,	2011
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Registrar NOV 1 6 2011 Chause A. Against		-	11. Date filed (Month, Day, Year) 32. R	egistrar's signatu	park	1				

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death . Decedent's Name (First, Middle, Last) NOVEMBER 13 2011 11:45A M Physician/ RAPHAEL Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** HARFORD AIR BEL 1304R SCOTTSDALE DRIVE 9. Birthplace (State or Foreign If Under 24 Hrs 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Hours 1 X M 2 🗆 F Director 215-34-6514 08/03/1938 MD 73 Usual Residence of Decedent 10d. Inside City Limits or 28a-f show 10c. City, Town or Location 10a. State the Medical Examiner must be notified at Director 1 Yes 2 X No BEL AIR HARFORD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Funeral USA 21015 1304R SCOTTSDALE DRIVE Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, filed within 72 hours after death 12. Was Decedent Ever in U.S. Black, White, etc. rmed Forces?
Yes 2 No 1 Never Married 2 Married Completed by "natural", or 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) MEDICAL ADMINISTRATOR 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) it. Page 1 and 2 should be fill thent of Health and Mental rtant; If item 27 is marked on jury or other traumatic events. ည KOREN DAISY RAPHAEL LOUIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1304R SCOTTSDALE DRIVE, BEL AIR, MD 21015 SANDRA RAPHAEL/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place)
MIKRO KODESH
BETH ISRAEL 20c. Location - City or Town, State 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If it any injury or o 11/16/2011 BALTIMORE, MD 4 Donation 5 Other (Specify) SOL LEVINSON & BROS., INC. 22. Name and Address of Facility Signature of Funeral Service Licens 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. week Immediate Cause (Final Lrosepsis Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner idacy Disease Cause (Disease or injury that initiated events To the Hospital or Attending Physician; The law requires that the death certificate be executed the burial-tran Flomerulo Sclerosis resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) in the past 12 months? Month Dav 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Hypothyroid 3 Probably 4 Unknown 2 No disease Completed 24b. Were autopsy findings available prior to completion of cause of death? metabolic acidosus Collegaa. Was an autopsy Diabetes Mellitus Yes 25. Was case referred to medica examiner? 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 I ဂ္ 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Manner of Death 5 Pending Natural 2 🗌 No within 24 hours after death.

To the Funeral Director, A completely filled in by the fu Investigation 6 Could not be Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifier Chesapeake Dr. BelAir, MD 21014 State Registrar

DHMH 17 Rev 06-2011

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State of Maryland / Department of Health and Mental Hygiene

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Physician/	Decedent's Name (First, Middle,Last)		Date of Death Month D November 1		3. Time of Death 0512 hrs
Tour Examiner	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November 1	4c. County of Death	00121113
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Director	220 00 01//	Months Days Hours Min.	April25	Torni-	
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ther death with or items to term ust be.	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	Was Decedent of Hispanic Origin? (Spf Yes, specify Cuban, Mexican, Puerto Yes 2 No specify:	Rican, etc.)	14. Race - Americ White, etc. Specify:	an
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours at Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural injury or other traumatic event, the Medical Examin Injury or other traumatic event, the Medical Examin To Be Completed by	Elementary/Secondary (0-12) College (1-4 or 5+)	lent's Usual Occupation (Give kind of w most of working life. DO NOT use retir	1,7%	6b. Kind of Business/Ir	N/A
21215-0036 and be filed within 7 Mental Hygiene. marked other than c event, the Medica TO BE COMPIE	17. Father's Name (First, Middle, Last) Bhakta Rijal	18.Mother's Name Bishnu	(First, Middle, Mai Rijal	den Surname)	
MD 21 tid 2 should tith and Me m 27 is ma aumatic en	Jagannath Rijal-Brother 1647	ling Address (Street and Number or R Shangle Road, Su	ite 6, Co	olumbus,Oh	io 23442
Baltimore, permit. Pages 1 and Departunt of Heal Important: If fee injury or other tra	1 Burial 2 Cremation 3 Removal from State crematory or Ardent	Cremation, Inc 11-	16-11	Hanover, M	aryland
Balt permit Depart Impor injury	21. Signature of Funeral Service Licensee 6	Name and Address of Facility 1009 Harford Road,	Marzullo Baltimore	Funeral C e,Maryland	napel,P.A. 21214
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ital Recician: The certificate rector, page	25. Was case referred to medical examiner?	26.Place of Death (Check of			
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Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Medical Certification	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occ (Check only one) 2 Medical Examiner: On the basis of examination and/or investige and manner stated.				
P S P S	29b/Signature and title of certifier (29c. License number O.C.M.E.		9d. Date signed <i>(Mon</i> November 15, 20	
\	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 900 W. I	3altimore Street, Baltimore, N	1D 21223		
State Registrar	31. Date filed (Month, Day Year) 32. Registrar's Signal 1				

11-08544 Anthony Ramsey

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	Funeral Director				(In yrs. last b	oirthday)	Months Days		Min	F	9. Birthplace (State or oreign		
	Director		215-98-6132	1XM 2F 3	19	Yrs.			08–17-	08-17-1972 Country) MD			
	Áu		Usual Residence of Decedent 10a. State 10b. County		IDc. City. Toy	vn or Location	<u> </u>				10d. Inside City Limits		
		١.	MD		,	IMORE					1 X Yes 2 No		
	rylan 'a-f sl	cţo	10e. Street and Number				10f. Zip Code			0g. Citizen of What			
	or 28	Director	3436 RAVENWOOI) AVENUE			70 Z.p 0000	21213	1	USA			
	Z15-UU36 be filed within 72 hours after death with the Maryland nall Hygiene. red other than "natural", or items 23a or 28a-f sho ent, the Medical Examiner must be notified at once.	-	11. Marital Status	12. Was Decedent E	ver in U.S.	13 Was	Decedent of His		(Specify Yes or No		American Indian, Black,		
	item	Funera	1 Never Married 2 Ma	rried Armed Forces?						White, e			
	fter d		3 Widowed 4 X Divo	1 Yes 2 orced If Yes, Give Year	No	1 Y	es 20 No	specify:		Specify:	BLACK		
	ours a	d by	15. Decedent's Education (Spec	ify only highest grade comp	oleted) 16		Usual Occupati			16b. Kind of Busin			
	72 hc	Completed	Elementary/Secondary (0-12)	College (1-4 or 5-	+)	during mos	t of working life.	DO NOT use	retired)				
Š	1036 rithin 72 ene. rr than Medical	m	12	-12-		SECURI:	ry offic	CER		HARBO	RPLACE		
	D-C		17. Father's Name (First, Middle,	Last)				18.Mother's Na	ame (First, Middle, M	Maiden Surname)			
Š	Z1Z15-U36 Z1Z15-U036 Uld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	WILLIAM RAMSE					JUAN		ITE			
	should and Mer	J.	19a. Informant's Name/Relationsh WILLIAM RAMSEY		1					ber, City or Town, S MD 2121			
	E pg g		20a. Method of Disposition	./12111121	20b Place		on (Name of cen		Date	20c. Location - Ci			
	F E E E E		1 Burial 2 Cremation	3 Removal from State		atory or other	place)	,					
	t. Pa		4 Donation 5 Other Spe 21. Signature of Funeral Service L	ecify:	METI	RO CREI	MATORY	15 30	1/22/11	BALTI	MORE, MD SONS F.H., INC		
Č	baltimo permit. Page Department of Important: injury or oth		21. Signature of Funeral Service L	.icensee									
	Physician	_	23a. Part I. Enter the disease, or o	complications that caused the	ne death. Do					MORE, MD	Approximate Interval		
	/Medical		failure. List only one cause of								Between Onset and Death		
	čxaminer		Immediate Cause (Final disease or condition resulting in death)	a.Cardiac Sar		SIS							
			Sequentially list conditions,	b	,								
		힅	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseq	uence of):								
		Examiner	(Lisease or injury that initiated events resulting in death) Last	c. Due to (or as a consec	Due to (or as a consequence of):								
	executed an and al - transit			d.	,								
	ial ia	/Medical	X UNPENDED	x AMENDED 15 1 23a,pt.II	per fh	g921	11-17-1	1 vt					
6	fou, ficate be of g physicia the buria	ğ	IF FEMALE:	23c. If yes, outcome	of pregnance	er me,			<u>SIII </u>	23d. Date of del	livery		
9	eath certification attending for use as t		23b. Was decedent pregnant in the past 12 months?	I Live Bildi	me of death		death 3	Ectopic pre	gnancy	Month	Day Year		
3	box bo death certif the attending of for use as	Physiclar	1 Yes 2 No 9 Unkr		ne or deau	5 Other	(Specify)						
	t the de	됩	Part II. Other significant condition	ons contributing to death I	out not result	ing in the und	erlying cause gi	iven in Part I,	23e. Did to	bacco use contribut	te to the cause of death?		
0	ires that the signed by	ğ	Hypertension						1 Yes	2 No 3	Probably 4 🗹 Unknown		
Ş	w requir	Completed							24a. Was a		re autopsy findings available		
Ğ	The law icate has I page 2 sh	ם							autop	med? deat			
۵	cian: The certificate ector, page		25. Was case referred to medical				26 Place	of Death (Che	1 Yes	2 No 1	Yes 2 No		
O observed letty of visiting	Nysician this cer	o Be	examiner?	Hospital: 1 Inpatient	2 F R/	Outpatient 3		Other 🗔		Residence 6 0	Other:		
Ę	After th	<u>':</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	28b	. Time of Inju		y at Work?		now injury occurred			
2	eath.	ţ	1 X Natural 5 Pendir		r)		1 Y	es 2 No					
	r Att	fig		igation 28e. Place of Injur	ry - At home,	farm, street,	factory, office bu	uilding, etc.			or Rural Route Number, City		
ć	pital or At ours after d neral Direct filled in by	Certification	4 Homicide determ						or Town, S	tate)			
	DIVISION OF VILAI RECOVERS, F.O. BOX 60 WITH RESOVERS, F.O. BOX 60 Within 24 hours after death, To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as			ysician: To the best of my l									
	To the How within 24 h To the Fur	edical	one) 2 Medical Exam	iner:On the basis of examination and manner stated.	nation and/o	rinvestigation	, in my opinion,	death occurre	ed at the time, date a	and place, and due	to the cause(s)		
	, , , ,	ž	29b. Signature and title of certifier	$\overline{\bigcirc}$			29c. License	number		29d. Date signed	(Month, Day, Year)		
			() (axulabe	ell)			O.C.N	1.E.		November 15	5, 2011		
ble	c pend	1	30. Name and address of person w										
	V	ا		sistant Medical Exan		u W. Balti	more Street	, Baltimore	e, MD 21223				
	Sta Regist	ate rar	31. Date filed (MorNOW Yar)	2011 32. Registrar's	400	bar	2						

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland A Department of Health and Mental Hydiene

			1-For Amend Item 26 per verb., 8921	Certificate of Death	r ivientai riyg	eg. No.	36774
H	Physicia	ın/	1. Decedent's Name (First, Middle, Last)		2. Date of Deat		3. Time of Death 1:32 PM M
	Medic		Joann Slabaugh 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Dear	
made	Examin	er	5561 Ashbourne Road	Halethorpe	2111	Baltin	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthday) If Under 1 Year If Under 24 Hr Months Days Hours Mir		9. Bir	thplace (State or Foreign
121	Director		217-58-8490	Yrs.	Feb 28,		ryland
	and show at	ě	The state of the s	n or Location			10d. Inside City Limits
	//aryla // 8a-f tified	Director	MD Baltimore Hale	thorpe			1 ☐ Yes 2X No
	a or 2 be no	Ö	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Co	ountry?
	h with	Funeral	5561 Ashbourne Road	21227		USA	
	r deat r iten iner i	y Fu	11. Marital Status 1 □ Never Married 2 □ Married 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 1 No	13. Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- rto Rican, etc.)	14. Race - Ame Black, Whit	
036	s afte ral", c Exam	ed by	3 X Widowed 4 □ Divorced 1 □ Yes 2 No If Yes, Give Year or Dates.	1 ☐ Yes 2 🔀 No Specify:		Specify: W	nite
5-0	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho er the Medical Examiner must be notified at , the Medical Examiner must be notified at	Completed		a. Decedent's Usual Occupation (Give kind of work done during most of work)	orkina	16b. Kind of Business.	/Industry
2	hin 72 ne. than '	omi	Elementary/Secondary (0-12) College (1-4 or 5+)	life. DO NOT use retired)	Orking	own hon	10
2	filed within al Hygiene. I other thai vent, the N	Be C	11 0	homemaker	ame (First, Middle, M		16
Maryland 21215-0036	should be file and Mental F is marked or raumatic even	To	Louis TRozzi		Betty Kuse		
ary	should and Me is mar raumati		19a. Informant's Name/Relationship (<i>Type, Print</i>)	b. Mailing Address (Street and Number or F	Rural Route Number,	City or Town, State, Zi	o Code)
Z.	○ ± 6 ±		Brian Slabaugh/son	5561 Ashbourne Road	Halethorp	e, MD 212	.27
Baltimore,	permit. Page 1 and Department of Hea Important: If item any injury or othe			of Disposition (Name of ery, crematory or other place)	Date	20c. Location - City or	Town, State
Balti	permit. Page 'Department or Important: If i any injury or once.		21. Signature of Funeral Service Livensee Diractor	23 Name and Address of Facility Boo		. Baltimor	e Street
			23a. Part 1. Inter the disease, or complications that caused the death. Do	Baltimore, MD 2 not enter the mode of dying, such as cardia		st,	Approximate
يديشيو	Physician/		shock, of teart fallure. List only one cause on each line. Immediate Cause (Final				Interval Between Onset and Death
	Medical		disease or condition resulting in death) a. Due to (or as a consequence	of):			years
	Examiner	T.	Sequentially list conditions, b.				
	sit sd	nine	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause (Ursease or Injury	of):			
	kecute and al-tran	Examiner	that initiated events resulting in death) Last C. Due to (or as a consequence	of):			
0	ficate be executed g physician and as the burial-transit	ical	d.				
	ificate ig phy as th	Med	IF FEMALE:				
9 ×	death certif ne attending ed for use a	ian/I	23b. Was decedent pregnant in the past 12 months?	h 3 Ectopic pregnancy		23d. Date of de	
Box	the at	Physician/Medical	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown	5 U Other (specify)		Month	Day Year
P.O.	requires that the des been signed by the s should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ds,	quires en sign culd be				1 □ Ye	es 2 X No 3□ P	robably 4 🗆 Unknown
Sor	aw rec as bee 2 sho	plet			24a. Was an		topsy findings available completion of cause of
Re	The Istantia	Completed			perform	death?	s 2 🗆 No
ita	sician: The law i certificate has b lirector, page 2 s	Be	25. Was case referred to medical examiner? Hospital:	26. Place of Death (Ch	eck only one)	1	
) (Phys r this o	2	1 Pes 20 No 1 Inpatient 2 ER/O	utpatient 3 DOA Other: 4 Nursing Time of 28c. Injury at	Home 5 Reside	nce 6 Other (Spec	cify)
on C	nding ath. 7. Afte ie fune	icate		injury work? M 1 Ves 2 No	20d. Describe flor	w injury occurred	
Division of Vital Records,	ol or Attending F s after death. I Director: After I d in by the funer.	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, fa building, etc. (Specify)	arm, street, factory, office	28f. Location (Str. City or Town,	eet and Number or Ru	ral Route Number,
ă	oital o urs af ral Di						
	To the Hospital or Attending Physician: The law requires that the within 24 hours after death. To the Funeral Director: After this certificate has been signed by th completely filled in by the funeral director, page 2 should be detach	Medical	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/only one)	or investigation, in my opinion, death occurred	d at the time, date and	place, and due to the	cause(s) and manner stated.
	Vorte Con		29b. Signature and title of certifier Out of Services CK	29c. License number 308.77	70	9d. Date signed (Mont)	h, Day, Year)
			30. Name and address of person who completed equse of death (Item 23a)	(Type, Print) 140 Eastern Ave	B'mo		21224
	Stat Registra	_	31. Date filed (Month, Day, Year) 32. Registrar's Signature	ake	//(0)	_ ,	
			THE STATE OF THE S				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ 2011 4:00 AMNovember Charles Jackson Stratton Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery General Hospital If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Pay, You Sept 18, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Months Davs Hours Year) 1920 Nebraska **Director** 235-14-6942 Usual Residence of Decede 1 👿 M 2 🗆 F 91 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location with the Maryland ms 23a or 28a-f sho must be notified at Director 1 Yes 2 X No Silver Spring MD Montgomery 10f, Zip Code 10e Street and Number 10g. Citizen of What Country? Funeral USA 20905 15317 Durant St. items death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces? ö þ 1 Never Married 2 M Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+ accounting CPA Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Leota Merle Nine Hazel Thornton Stratton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code, 15317 Durant St; Silver Spring, MD 20905 19a, Informant's Name/Relationship (Type, Print) Lisa Ann Stratton - wife 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Signatur of Funeral Se nn 655 W. Baltimore St; Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ - yolfa disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner attending physician and I for use as the burial-transit Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death ate has been signed by the a page 2 should be detached to Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 Yes 2 No this certificate 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 🗆 Yes 2 XNo 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Medical Certificate: 28d. Describe how injury occurred

Division of Vital Records, P.O. Box 68760

6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier

injury

(Check only one) 2 Medical Examiner: On the basis of examination and/or investigatic only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, deat		
Bichhum M Ginh	29c. License number	29d. Date signed (Month, Day, Year) November 11 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dichhuono 'in h Prince 18101

Drive, Ulney Philip

State Registrar 31. Date filed (Month, Day Registrar's Signatu NOV 17 2011

within 24 hours after death. To the Funeral Director, After

1 Natural

Accident

5 Pending Investigation

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 201 For State Registrar Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Raymond No Dembere 12 2011 Physician/ Spark man Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death IChRIST 405 Baltimore 10W50M Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 60-7914 North Corolinia **Director** 1 M 2 - F -10-1942 28a-f show Examiner must be notified at 10c. City, Town or Location Director Baltimore 1 Yes 2 No 10e. Street and Number ö 10g. Citizen of What Country? items 23a Funeral Orlean Steees 2/23/ USA 2106 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 14. Race - American Indian. 0 ģ 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Black permit. Page 1 and 2 should be filed within 72 hours aff Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Completed 3 Widowed 4 Divorced Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Goodwin Scatood Kitchen other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) monl Spankman Manha Informant Name/Relationship (Type, Print) 19a 19b. Mailing Address (Street and Numb or Rural Route Number, · Sparl Cma STREET 20a. Method of Dispo 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 5 1 🗌 Burial 🔁 Cremation 3 🗌 Removal from State Balto. injury 4 Dong 5 Other (Specify) Signature of Functar Service Licensee Part 1. Enter the disease, shock, or beart failure. Li complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition NEE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 the use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 Live Birth 2 Pregnant at time of death in the past 12 months? 1 Yes 2 No g Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ To the Hospital or Attending Physician: The law requires within 24 hours after death. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy ours after death.

eral Director: After this certificate I filled in by the funeral director, pag 1 Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 1 Yes 2X No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Sian 29c. License number 86115000 11-10-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Rrint) rely 0 101 Registrar

Please Type or Print in Black Indelible lnk. Ensure All Copies Are Legible.

		For State Registrar		State of Ma	ıryland / I	Depa <i>Cer</i>	rtment of H tificate of L	ealth and D <i>eath</i>	d Mental H	lygiene Reg. No	/ 1 1	1	36777
Physicia	n	1. Decedent's Nam	ne (First, Middle, Las	et)					2. Date of Month	Death Da	ıy Yea	ar	3. Time of Death
/Medic	al .		h E. Seam	Print.			4b. City, Town, or	Location of Do	11	16	201 County of D		3:30 AM M
Examine	er		l Nursing	e street and number)					satti	1	Baltim		
Funeral		5. Social Security N	Number 6. S	ex 7. Age	(In yrs. last bi	irthday)	Baltimo If Under 1 Year Months Days	If Under 24 F					e (State or Foreign
Director		190-20-9	779	X M 2□ F	-85	Yrs.	World S Days	riours IVI	03/28				sylvania
land ow	-	Usual Residence o 10a. State	10b. County		10c. City, Tov	vn or Lo	cation					10d	Inside City Limits
Mary -f sho	ţo	MD	Baltim	ore	Kings	sv: 1	le						1 □Yes 2 X No
th the or 28a a noti	Director	10e. Street and Nu		020	111191	7477	10f. Zip Code			10g. Ci	tizen of What	Country	?
ath wi		8004 Ye	llowstone				21087				S.A.		
er de	Funeral	11. Marital Status	ried 2 🕅 Married	12. Was Decedent E Armed Forces?		13. \	Vas Decedent of Hi f Yes, specify Cuba	spanic Ongin? In, Mexican, Pi	? (Specify Yes or uerto Rican, etc.)	No-	14. Race - A Black, W		
5-UU30 72 hours after death with the Maryland natural", or Items 23a or 28a-f show dical Examiner must be notified at	کر ا	3 Widowed		1 XYes 2 □ N If Yes, Give Year or Dates:	ww II	'	□Yes 2M∏No	Specify:			Specify:	Whit	e.
72 hou	ted	(Sne	15. Decedent's Ec	lucation			lent's Usual Occupa		working		Kind of Busine		*
ifthin 7	Completed	Elementary/Sec		College (1-4or 5	+)	`life. L	OO NOT use retired)	WOIKING	l l	ltimore		-
Hygier Ther th		17 Father's Name	(First, Middle, Last)	6		Te	acher	18. Mother's I	Name (First, Mid		nool Sy	ste	R
and d be fill ental H ced oth c even	To Be	Martin							uerite F				
shoul shoul mark	ř		lame/Relationship (Type. Print)	19	b. Mailir	g Address (Street a					te, Zip C	ode)
and 2 and 2 saith a 27 is er tra		Caroli	ne J. Sea	mon (wife			Yellowsto	ne Roa	d - Kind	svil]	le, Mar	ryla	nd 21087
DESIGNATION CHE, WISTY JATING ZIZIO-UUSO permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Dis	•	Removal from State	20b. Place cemet	of Dispo <i>ery, crer</i>	sition (Name of natory or other plac	e)	Date	20c. L	ocation - City	or Tow	n, State
altimo		4 ☐ Donation	5 ☐ Other (Specif	y)	Metro	c Cr	ematory,	Inc.11	/17/2011	Ba]	ltimore	e, Ma	aryland
Dal permi Depar Impo any Ir		21. Signature of F	uneral Service Licer	isee									Home, P.A. nd 21087
		23a. Part1. Enter	the disease, or com	plications that caused	the death. Do						ic, nai	-	opproximate
Physician		Immediate Cause	(Final	one cause on each lin	ne.	0	rA					ä	nterval Between Onset and Death
/Medical		disease or condition resulting in death)		a Due to (or as	a consequence	of):							
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ed sit	ine	Sequentially list of cause. Enter Und Cause (Disease o	erlying r injury	Due to (or as	a consequence	of:	n Evi						
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COIGS, P.O. BOX 08/00, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	edical		•	_d									
rtifical ng phy		IF FEMALE:											
death certi	Physician/M	23b. Was deceded		23c. If yes, outcome 1 ☐ Live birth	2 Fetal dea		Ectopic pregnancy	/		1	23d. Date of Month		ay Year
the de	ysic	1 ☐ Yes 2 9 ☐ Unknow	□No	4□Pregnant at 9□Unknown	time of death	5L	Other (specify) _			-			
ords, F.C requires that the een signed by th rould be detache		Part II. Other sign	ificant conditions	contributing to death be	ut not resulting	in the u	nderlying cause giv	en in Part I.	23e. C	oid tobacco	use contribu	te to the	cause of death?
cords w requires been sign should be	ed by								_ 1	☐ Yes	2□ No 3□] Probal	bly 4 Inknown
D & & C	Completed									Vas an	24b. Wer	e autops	sy findings available oletion of cause of
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ON OF VITAL F ding Physician: Th After this certificate funeral director, pag	Be	25. Was case refe examiner?		Hospital:			Oth		Death (Check or	nly one)			
Phys rat dir	٩ ا	1 ☐ Yes 2 ☐ 27. Mann of Dea		1 ☐ Inpatie		Outpatier . Time o	IL 3 DOA	4 Nursir	ng Home 5 ☐ F		6 ☐Other (ury occurred	Specify)	
Attending F r death. ector: After by the funera	ţ	■ Matural 2 Accident	5 Pending investigation	(Month, Day		Injury	f 28c. Injur Wor M 1 □	k? Yes 2∐No		,	,,		
INISION Or Attending after death. Director: Afte	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not b determined	28e. Place of inju- building, etc	ury - At home,	farm, sti	reet, factory, office		28f. Locatio	on (Street a	and Number o	or Rural	Route Number,
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UNISIC To the Hospital or Attend within 24 hours after death To the Funeral Director: /	lical	29a. Certifier (Check only one)		nysician: To the best miner: On the basis of and manner sta	f examination a								
To the within 2 To the comple	Medi	29b. Sigrature an	d title of certifier	and manner sta	aiGU.		29c. Licens	e number		29d. D	Date signed (A	Month, D	ay, Year)
->F0		Man	n MD				D	7772	7	11	16	il	
16x'		30. Name and add	dress of person who	completed cause of d	eath (Item 23a) (Type	Print)			/	0 1	-14 	1
3		None	vale 12	haven	881	31	NOVUIN	am	Wood	ds 1	wa	1 NI	1) 21236
Sta Registr		31. Date filed (Mo	NOV 1 7 2	011 32. Hogier	ar's Signature	Jo.	arkel						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / Department of Hea		ental Hyg	giene 2011	36778
			Registrar Certificate of Dea	ath ———		Reg. No.Z U I	
	Physicia Medic				2. Date of Dear Month		3. Time of Death 11 5: 26 AM
	Examin			1		4c. County of Dea	e George's
111	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If L	Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 3,		rthplace (State or Foreign ountry) Na
	M.		Usual Residence of Decedent				
	yland -f sho ed at	Director	10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Mar r 28a notifi	Ji.e	MD Prince George Laurel				1 🗆 Yes 2 🔀 No
	ith th 23a o st be	ra l	106. Street and Number 10f. Zip Code 8778 Oxwell Lane 20708			10g. Citizen of What Co	ountry?
	ath w	Funeral	8778 Oxwell Lane 20708 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispan	anic Origin? (Spec	ifv Yes or No-	U.S.A.	erican Indian
21215-0036	I and 2 should be filed within 72 hours after death with the Maryland if Heath and Mental Hygiene. If Heath and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by	1 Never Married 2 Married 1 Never Married 2 Married 1 Never No	Mexican, Puerto F		Black, Whit	te, etc.
Š	hours natur lical I	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation			16b. Kind of Business	
212	iin 72 e. han "	l iii	(Specify only highest grade completed) (Give kind of work done during Elementary/Seconday (0-12) College (1-4 or 5+) life. DO NOT use retired)			Maryland S	State
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Maryland	be filer ental H ked ot c ever	To B		B. Mother's Name Eva The		,	
<u> </u>	nd Me marl	Ŋ	19a. Informant's Name/Relationship (<i>Type, Print</i>) 19b. Mailing Address (<i>Street and N</i>				in Code)
Ĕ	d 2 sh alth a 27 is rrtrau		Paula M. Steele /spouse 8778 Oxwell Lar			•	
			20a. Method of Disposition 20b. Place of Disposition (Name of		ate	20c. Location - City of	
Ē	Page 1 nent of ant: If it		1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	ry Nov 1	5, 11	Odenton, M	aryland
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licurisee 22. Name and Address of Donaldson Ft 313 Talbott	f Facility uneral I	Home, P	.A. Marvland 20	0707-4389
	•		23a. Part 1. Enter the chease, or complications that caused the death. Do not enter the mode of dying, su shock, or heart failure. List only one cause on each line.				Approximate Interval Between
P	h sician/	3 0	Immediate Cause Final disease or condition Acute Thoracic Aorti	'c Rui	oture		Onset and Death
المر	Medical Examiner		resulting in death) Due to (or as a consequence of):				
	sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying				
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9/89	ng phy as th	Med	IF FEMALE:				
S X	tn cer ttendii or use	ian/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 3 Ectopic pregnancy			23d. Date of de	
Pox	To the brophal or Attending Priysician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/Me	1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown			Month	Day Year
л Э	gned b	þ	The trib. Other significant conditions contributing to death but not resulting in the didentifing cause given in	in Part I.	23e. Did to	bacco use contribute t	o the cause of death?
ds,	equires sen siç ould t	ted	Hypertension		1 🗆 Y	∕es 2 X No 3 □ 1	Probably 4 Unknown
Vital Records,	hasbe e 2sh	Completed			24a. Was a autop	sy prior to	utopsy findings available completion of cause of
֡֟֟֝֟֝֟֝֟֝	i: Ine licate r, pag					2 No 1 Ye	es 2 XNo
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JIVISION OT	frer de linecto	Certificate:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	2	28f. Location (S: City or Town	treet and Number or Ri n, State)	ural Route Number,
5	pura ours a eral D	cal	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date	1		(*)	
-	e nos 124 h e Fun sieted	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time	death occurred at	the time, date ar	nd place, and due to the	cause(s) and manner stated.
ř	Vithir Comp	-	29b. Signature and title of certifier 29c. License nun	· · · · · · · · · · · · · · · · · · ·		29d. Date signed (Mon	
	, 2		Jus Marin Door	10842		11/12/2	611
	10		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	00 Van			Laurel, MD
	Stat	e	Arleen Allen M.D. Laurel Regional Hospi 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Ital, E	merge	ncy Dep	t. 20707
	Registra		NOV 1 7 2011 Course A back				

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36779 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Mont 12:00 AM 201 ununes Medical 4a. Facility Name (it not institution, give street and number) Town, or Location of Death County of Deatl **Examiner** tarbour mardis 1 Year I Under 24 Hrs. Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year) Director 303-26-7748 1 🗆 M 2 🗶 F 85 1926 Indiana May 7, ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 Yes 2 X No MD Prince George's Bowie 10e. Street and Number 10g. Citizen of What Country? items 23a Funeral 20715 United States 12145 Long Ridge Lane death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Examiner Black, White, etc. or . þ 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: "natural", 3 X Widowed 4 Divorced White Completed Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done of life. DO NOT use retired) (Specify only highest grade completed) kind of work done during most of working Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. United States Elementary/Secondary (0-12) College (1-4 or 5+) Administrative Assistant Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ Alfred Obergfell Clara Marie Zeph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crawfords Ridge Road Odenton, Maryland 21113 Suzanne M. Raley / Daughter item 2 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date permit. Page 1 s
Department of H
Important: If ite
any injury or ot 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Resurrection Cemetery 11-17-2011 Clinton, Maryland Signature of Funeral Service Licensee Name and Address of Facility Donaldson Funeral Home & Crematory, P 1411 Annapolis Road Odenton, Maryland House 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arresi Approximate Interval Between shock, or heart failure. List only one caus on each line theroscla Caremorasaula Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to mimediate cause. Enter Underlying Cause (Disease or injury Examine Due to for as a consequence on the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) ding physician by Physician/Medical Records, P.O. Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Other (specify) q | Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. pe 1 Yes 2 No 3 Probably 4 Vunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 1 🗌 Yes 2 🗆 No this certificate 2 N Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 No 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 \(\subseteq \text{Yes} 28b. Time of 27. Manner of Death 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending injury n 24 hours after death. le Funeral Director: Af bletely filled in by the fu 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune

completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 44 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

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Tidewater (down

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36780 _ State Reg. No. 2 Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 1.1 Physician/ N. SAVICE LARRY 2011 2:45 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 2009 WALDEN **CHARLES** BRYANS ROAD 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex **Funeral** Hours 2/10/1981 LIBERIA 410-89-7645 X M 2 D F **Director** 30 Usual Residence of Decedent or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 0a. State 10h County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21201 Funeral 15 CHARLES PLAZA #1408 Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Black, White, etc. Armed Forces Never Married 2 Married þ Yes 2 No Yes, Give Specify: BLACK Saltimore, Maryland 21215-0036 1 Yes 2X No Specify: 3 Widowed 4 Divorced Completed Year or Dates 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retire and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) BANKING BANK TELLER 12th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 WINIFRED W. WITHERSPOON CHRISTOPHER SAVICE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trau WINIFRED W. BENSON/MOTHER 2009 WALDEN CT BRYANS RD., MD. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition 1 💢 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Danation 5 ☐ Other (Specify) LINCOLN MEM. CEM. 12/3/2011 SUITLAND, MD 22. Name and Address of Facility 21. Signati Funeral Service Lio CAPITOL MORTUARY MARYLAND AVE NE WASHINGTON DC 20002 not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between mplications that caused the death. Do 23a. Part 1. Enter the disease shock, or heart failure. Li Onset and Death Immediate Cause (Final -Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine Due to (or as a consequence of): ri any, Isacing to immediate cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of ate has l 1 Yes 2 XNo certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Other:
4 | Nursing Home 5 | Residence 6 \(\) Other (Specify) HOME examiner? Hospital 1 Yes 2 XNo 1 Inpatient 2 ER/Outpatient 3 IDOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Mapner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Ccident work? 5 Pending injury 2 🗌 No s after death. I Director: Af Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ò 4 Homicide determined filled in 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hore To the Fune completely f 29b. Signature and title of certifie 29c. License number

Registrar DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

0

32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Type, Print)

TOIES, YUYA Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh 9923 1-3-12 yr. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 7 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dora C. Toles Month Day Year Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Charles Village N/A Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 🗷 F Months Days Hours Yrs Director 212-26 8/19/1931 Usual Residence of Decedent "natural", or items 23a or 28a-f shov idical Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits with the Maryland Director 1 🗶 Yes 2 🗌 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21205 509 N. Castle St. hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Black Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "ns
any injury or other traumatic event, the Medic (Give kind of work done during most of working life. DO NOT use retired) within 72 Elementary/Seconday (0-12) Çollege (1-4 or 5+) 8th N/A <u>Factory Worker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hazel Carter Harvey Cross 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3817 Crestlyn Rd. Baltimore, MD 21218 Earl Toles Jr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ■ Burial 2 □ Cremation 3 □ Removal from State 11/14/2011 Owings Mills, MD 4 Donation 5 Other (Specify) Garrison Forest Signature of Sueral Service Licensee 22. Name and Address of Facility March F/H 1101 E. North Ave. 21202 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Progressive Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed has been signed by the attending physician and ge 2 should be detached for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Discare mth Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Hospital Other: 2 No 1 🗌 Yes Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work' М 1 Tes 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month)

MID

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

D31464

MD 221 N. EVTAWST Shite 305 Balhowere MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36782 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ΪΌ, 2011 5:19 November <u>George Grant Thomas</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Howard Columbia Gilchrist Hospice . Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year)1929 Months Hours June 24, 1 X M 2 □ F Maryland Yrs. **Director** 219-24-8144 82 Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits the Medical Examiner must be notified at Director 1 Yes 2 □ No Baltimore MD 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Funeral USA items 23a 21211 3939 Roland Ave #712 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married "natural", or δ Baltimore, Maryland 21215-0036 white If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) insurance insurance salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Mary Loretta Donahoe George G. Thomas permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 634 Piccadilly Rd; Towson, MD 21204 Mary E. Scott - niece 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board o Luneral Service Ronal d rector 655 W. Baltimore St; Baltimore, MD 21201 ansi 23a. Part 1. Soler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death COLON Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-trans and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Yes 2 No 9 🗌 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by EMPHYSEMA 1 Yes 2 □ No 3 □ Probably 4 □ Unknown ATRIAL FIBRILLATION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical the funeral director, æ 26. Place of Death (Check only one) examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\mathbb{X}\) Other (Specify) Hospital 1 ☐ Yes 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director: / 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 1 🕭 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. сопреted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D64395 NOVEMBER 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CEDAR LANE COLUMBIA, MD 21044

Registrar

31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death · I<u>5</u> Physician/ Mary Carmella Thompson 2011 4:25 P November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Seasons Hospice Randallstown Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours **Director** 192-14-4928 1 M 2 X F 89 Yrs. October 9, 1922 Pennsylvania 28a-f show 10b. County 10d. Inside City Limits the Medical Examiner must be notified at 10c. City. Town or Location Director Maryland Baltimore 1 Yes 2X No Towson 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 302 E. Joppa Road, #802 21286 United States items : 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. o. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 Yes 2 X No Specify: than "natural" 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 Administrator Federal Government Be Department of Health and Mental H Important: If fem 27 is marked oth any injury or other traumation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Samuel Vanchieri Josephine Cardamone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Gronning/Niece 302 E. Joppa Road, #802, Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place)
Gate of Heaven
Cemetery November 21, 4 ☐ Donation 5 ☐ Other (Specify) 2011 Silver Spring, Maryland Signature of Funeral Service 22. Name and Address of Facility Robert Pumphrey Funeral Home/ Α. Bethesda-Chevy Chase Inc. Bethesda, Maryland 20814 7557 Wisconsin Avenue M01498 23a. Part 1. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ Endstage Chronic Obstructive Pulmonary Disease disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Directo (or as a nonsequence of): cause. Enter Underlying Cause (Disease or injury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Exami that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? performed? 1 Yes 2 No Yes 2 X No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6x Hospice Inpatient 2 🔀 No မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 1 X Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Curtifying Nurse Fractitioners To the best of my knowledge, doest". Consumed at the time, date and place, and due to the cause(s) and manner as state 29b. Signature and title of certifie 29c. License number MSRajapakneM.D DO057465 11/16/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 06-2011

N. SiRajapakse, M.D

31. Date filed (Month, Day, Year)

2835 Smin AV

32. Registrar's Signature

5203 Baltimore MD 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				artment of Health and Natificate of Death	Reg. No	2011	36784						
Р	hysicia	ın/	1. Decedent's Name (First, Middle, Last) Ernest Edward Vogel		2. Date of Death November 1	ah 2019ah	3. Time of Death 8:23 a.M						
	Medic Examin		4a. Facility Name (if not institution, give street and number) Casey House	4b. City, Town, or Location of Death	40	County of Death	0.23 aw						
Di	uneral		5. Social Security Number 219-42-4003 Usual Residence of Decedent 6. Sex 7. Age (In yrs. last birthday) 67 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) July 15, 1	9. Birthp	olace (State or Foreign try) DC						
Maryland	28a-f shov otified at	Director	10a. State 10b. County 10c. City, Town or Lo			1	0d. Inside City Limits 1 ☐ Yes 2xxxNo						
ith the	23a or st be n	ralD	10e. Street and Number 2340 Briggs Chaney Road	10f. Zip Code 20905		10g. Citizen of What Country? USA							
15-0036 72 hours after death with the Maryland	ad other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☒ No Specify:		14. Race - Americ Black, White, Specify: Whi	etc.						
21215-00 within 72 hours giene.	than "natura te Medical E	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Education (Give	dent's Usual Occupation kind of work done during most of worki O NOT use retired) Mechanic	ing	Kind of Business/Inc							
Maryland 2- should be filed wit	rked other tic event, th	To Be C	17. Father's Name (First, Middle, Last) William Joseph Vogel	18. Mother's Name	e (First, Middle, Maiden lizabeth Le	Surname)	THISCALLACT						
Mary 2 should h and №	7 is ma traumat	- 1	19a. Informant's Name/Relationship (Type, Print)	ng Address (Street and Number or Rura	-								
Baltimore, Maryland 21215-0036 sermit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hydiene.	Important: If item 27 is marked any injury or other traumatic ev once.	1	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposerery, cre	matory or other place) Novem	Date 20c. L	ocation - City or Ton							
Balti permit. P	Importa any inju once.		21. Signature of Funeral Service Licensee 2	2. Name and Address of Facility Dona 313 Talbott Ave., 1	aldson Fune	eral Home	, P.A.						
M	sician edical iminer	er	23a. Parth. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Rectosigmoid Junction Cancer Due to (or as a consequence of): Sequentially list conditions, if any, feating to immediate										
death certificate be executed	hysicia the buri	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence of): d.										
death certif	e attending	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ery Day Year						
do, r.O.	en signed b	by	Part II. Other significant conditions contributing to death but not resulting in the Liver Cancer	underlying cause given in Part I.		use contribute to th	ne cause of death?						
The law re	certificate has be lirector, page 2 sh	Completed	Lung Cancer		24a. Was an autopsy performed?	prior to co death?	osy findings available mpletion of cause of						
VILCII ysician	is certifi director	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death (Check	me 5 ☐ Residence 6	S K Other (Specify	Hospice						
To the Hospital or Attending Physician: The law requires that the within 24 hours after death.	irector: After thin by the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined 28a. Date of injury (Month, Day, Year) 28b. Time of injury 38b. Time of injury 28b. Time of injury 38b. Time of injury 28b. Time of injury 38b. Time of injury 3b. Time of i	f 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how injur 28f. Location (Street am City or Town, State	y occurred d Number or Rural							
re Hospital on 24 hours at	ne Funeral E	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death (Check only one) 3 Certifying Nurse Practitioner: To the best of my knowledge	tigation, in my opinion, death occurred at	nd due to the cause(s) a the time, date and place	ind manner as state	use(s) and manner stated.						
To th withii	COM)		29b. Signature and the of certifier Advan Multr CRNP	29c. License number R143201		te signed (Month, I							
5	11		30. Name and address of person who completed cause of death (Item 23a) (Type, IDebrah Miller, CRNP, 1355 Piccard Dr.		ville, MD 2	20850							
R	Stat legistra	_	31. Date filed (Month, Day, Year) NOV 1 7 2011 Summ S. Signature S. Sparks										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 0658 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 636 Dunberry Drive Arnold Anne Arundel Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea **Funeral** 6. Sex Age (In yrs. last birthday Days 1 M 2 Hours Director 177-34-8385 68 1943 March 6, Pennsylvania Usual Residence of Decedent 28a-f shov uld be filed within 72 hours after death with the Maryland Mental Hygiene. "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Arnold Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 21012 636 Dunberry Dr. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🕅 No Black, White, etc. ģ 1 Never Married 2 Married 1 ☐ Yes Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) financial accounting rep Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Margaret Allen Norman Thomas Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 636 Dunberry Dr; Arnold, MD 21012 Megan Lowe - daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place, ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Foard of Funeral Service frector 655 W. Baltimore St; Baltimore, MD 21201 m Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer ock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) ue to (or as a consequence of) Examiner Sequentially list conditions Examine Due to jor as a consequence of cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician use as the burial Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 month ō Month Day Year Pregnant at time of death ed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Hiknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of has page 2 autopsy performed' death? Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner are eath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 ___atural 5 \square Pending work? 1 🔲 Yes 2 🗋 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36786 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 21:20 M harles Donald November 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death saltimore The Johns Hopkins Hospital 8. Date of Birth Birthplace (State or Foreign Country) Age (In vrs. last birthdav) If Under 24 Hrs **Funeral** 219-30-3928 Months (Month, Day, Year, **Director** 1 🖾 M 2 🗆 F Oct. 26, 1934 Maryland 77 Usual Residence of Deced 28a-f show notified at 10a State 10c. City, Town or Location 10d. Inside City Limits Director 1 Ves 2 X No Ellicott City MD Howard 10e. Street and Number ö 10f. Zip Code 10g, Citizen of What Country? must be n Funeral 3346 Coventry Court Drive 21042 USA items death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, er than "natural", or iter the Medical Examiner rmed Forces?

X Yes 2 No Black, White, etc. δ 1 Never Married 2 Married Maryland 21215-0036 hours after White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Specify 3 ☒ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) should be filed with and Mental Hygien 7 is marked other the Mechanical Insulator Construction 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည James Joseph Waters Katherine McDonnell other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Park Drive; Catonsville, MD 21228 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other Daughter Mary Beth Audy Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Crest Lawn Mem. Garden 11/19/2011 Marriottsville, MD 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Ashton Schwab Witzke Sterling 21. Signature of Funeral Service License Name and Address of Facility Sterling Ashton Strungeral Home of Catonsville, Inc. 630 Edmondson Avenue: Catonsville MD 21228 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Between Immediate Cause (Final Onset and Death Ph sician/ A interation cute myocardial disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner mesotheliona Malignant Sequentially list conditions Due to (or as a nsequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examir burial-tra Due to (or as a consequence of) resulting in death) Last Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 phys the t nding p IE EEMALE nse 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ō in the past 12 months? Month Day Year Pregnant at time of death 2 No g 🗌 Unknown g Unknown igned by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? a A 1 Yes 2 No 3 Probably 4 Unknown Completed . Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsv perforn death? 1 Yes 2 No Yes 2 X No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 🗆 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 1 Matural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? after death. 2 🗌 No filled in by the Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide City or Town, State) within 24 hours a To the Funeral C To the Hospital Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier completely (Check Gertifying Nurse Practitioner. To the best of my knowle 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) November 15 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Anwkka A.R.Antar

LOO N.Wolfe

Registrar DHMH 17 Rev 06-2011

State

Date filed (Month, Day, Year)

NOV 1 6 2011

Baltimore MD 21287

600 N.Wolfe

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULIAN Physician/ 3:47 PM WEBB 14,2011 NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDICAL CENTER TOWSON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Year) 219-37-4858 **Director** 1 **№** M 2 🗆 F 18 Yrs. MD 01/29 1993 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at **Funeral Director** MD PARKVILLE 1 Yes 2 No ö 10e. Street and Number 10g. Citizen of What Country? 23a USA DOWLING CIRCLE - APT 21234 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc Yes 2 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: BLACK 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) STUDENT STUDENT 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ HUNDLD WEBB GLENNIS TUCK 19a. Informant's Name/Relationship (Type, Print) . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DOWLING CIRCLE-APT TI. PARKVILLE, MD 21234 GLENNIS TUCK (MOTHER 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 MBurial 2 Cremation 3 Removal from State cemetery, crematory or other place) 11/22/11 BATIMORE, MD KING MEMORIAL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility VAUGHN GREENE FUNERFUL Sovs 21. Signatur of Funeral Service Licensee 4905 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph sician/ ANOXIC ENCEPHAL disease or condition Medical resulting in death) **Examiner** RESFIRATORY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-trar that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ ate has been signed by the atte page 2 should be detached for in the past 12 months?

1 Yes 2 No Pregnant at time of death 1 ☐ Yes ≥ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 prior to completion of cause of death? autopsy performe Yes 2 No 1 Yes · 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 2 X No Other: ၉ 1 🗌 Yes 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 🔀 Natural 5 \square Pending 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND KHOSROW USLER 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 06-2011

Registrar

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Month Year **Physician** 8:25 p.m. Sheila Walker 10-25-2011 /Medical 4b. City, Town, or Location of Deeth 4a Fecility Neme (If not institution, give street end number) 4c. County of Deeth Examiner N/A Baltimore Genesis Hamilton Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yeer) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** Days Hours Months 1 ☐ M 2 🛛 F 214-54-3628 Yrs 61 Director 10/14/1950 MD Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Merylend Depertment of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1⊠Yes 2□No Director Baltimore N/A 10g. Citizen of What Country? 10a Street end Number 10f. Zip Code 21206 5536 Cedonia Ave. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🎝 No If Yes, Give Race - American Indian, Black, White, etc. 11 Maritel Status 1 ☐ Never Married 2 ☐ Married Specify: Black 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: à 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hospital N/A Nursing Assistant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Fether's Neme (First, Middle, Last) Elizabeth Wheeler Osbie Wiley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) Charity Wiley-Sister 5502 Frankford Ave. Baltimore, MD 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Greenmount Cemetery 11/7/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H 1101 E. North Ave. Baltimore, MD 21202 21. Signature of Fiveral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical rancham Examiner Due to (or as a consequence of) Examiner Division of Vital Records, P.O. Box 68760, attending physician and for use es the burial-transit law requires that the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of). Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the a 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Me ٥ 24b. Were eutopsy findings Completed 24a. Was an autopsy performed? available prior to completion of cause of deeth? page 2 s certificata has 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica complately filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: Unursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🗀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated edical (Check only 2 Medical Examin Now You the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29d. Date signed (Month, Dey, Year) certifier 29c. License number 29b. Signature end title of Re Parlame MD 21284 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) 40 8813 Waltham W Mitter 31. Dete filed (Month legistrar's Signature State

DHMH 16 Rev 6/95

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36789 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ November 2011 9:55 PM Mary R. Wiseman Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Edenwald Retirement Community Baltimore Towson If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Date of bir... (Month, Day, Year) ne 18,1910 **Funeral** Days Hours 214-40-5409 Baltimore, MD Director 1 □ M 2 → F June 101 Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. Count 10c. City, Town or Location Director MD Baltimore Towson notified 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ō must be 23a Funeral 800 Southerly Road 21286 United States . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after Specify: White 1 ☐ Yes 2X No Specify "natural" Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work dane during most of working life. DO NOT use retired)

Teacher/Counselor/Principal (Specify only highest grade completed) of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me Elementary/Secondary (0-12) Baltimore City College (1-4 or 5+) Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Barbara Baummer ျှ Samuel William Wiseman 19a. Informant's Name/Relationship (Type, Print) Nephew 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Wiseman, Jr. 4814 22nd Road N. Arlington, VA 22207 20b. Place of Disposition (Name of Events Screpts Screpts Screpts Screpts Screpts Screpts Screen Place)
Chapel – Bel Air 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 🏿 Cremation 3 ☐ Removal from State 5 November 17, Department of Important: If any injury or once. Forest Hill, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 21. Signal re of Funeral Service Licen ee ₩8^ቸመዅ€ጕ፝፞ቑ፝ገ Chapel & Cremation Serviœ 0 Harford Rd. Parkville, MD 21234 色Van 8800 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disea or condition resulting in death) Physician/ Medical Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) the attending physician and hed for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death be detached Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed need . Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No this certificate has 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital 2 🗓 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 5 Pending work 1 ☐ Yes 2 ☐ No M ☐ Accident Investigation completely filled in by the Suicide 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State, 24 hours Medical

within 2.

State Registrar

29a. Certifier

(Check

only on 29b. Signa

title of ca

son who completed cause

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TITEM# 30 per DVR, G921, Ink, Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 36790 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Weisberg Physician/ Month Maurice 1254 PM November 201 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death MILS Village Baltmore Social Security Number 6. Sex Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 212-24-7680 Director 1 XM 2 □ F 97 10/01/1914 MD Usual Residence of Deceden 28a-f show 10a. State with the Maryland Director 10b. County 10c. City, Town or Location 10d. Inside City Limits notified 1 Yes 2 No MD BALTIMORE OWINGS MILLS 5 10e. Street and Number 10g, Citizen of What Country? must be Funeral 23a 4730 ATRIUM COURT, APT. #162 USA 21117 death v 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Armed Forces 1 X Yes 2 If Yes, Give Year or Dates. Black, White, etc o Completed by 1 Never Married 2 Married 2 🗆 No Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 Yes 2 X No Specify WHITE 3 ₩ Widowed 4 Divorced Specify "natural" Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meonce. Elementary/Secondary (0-12) College (1-4 or 5+) 5+ COLLEGE PROFESSOR **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **EDWARD** WEISBERG HIMMELFARB REBECCA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ROBERT WEISBERG/SON 6118 TILDEN LANE, ROCKVILLE, MD 20852 20a. Method of Disposition
1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) CARROLL CREMATION INC: 11/16/2011 HAMPSTEAD, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Arterrosclerotic cardiovascular disease Physician/ disease or condition resulting in death) years Medical Due to (or as a consequence of Examiner Hypertention Years Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury e to (or as a consequence of) Examir burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. that initiated events resulting in death) Last Due to (or as a consequence of) physician a Physician/Medical Division of Vital Records, P.O. Box 68760 the attending p as IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Year Month Day 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chrome Kidney discose 1 ☐ Yes 2 Ø No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: performed 2 🗆 No Yes 2 1 Tyes In Home 25. Was case referred to medical Be 26. Place of Ceath (Check only one) examiner? Hospita 2 No Other: ျှ 1 Tyes 4 Nursing Home 5 Residence 6 Other (Specify 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗆 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and on investigation, many special and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D358 November 15 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

David Roggen

NOV 1 7 2011

Pikesville, Md 21208

4000 Old Court Road

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 | State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** SEASONS HOSPICE @ NORTHWEST HOSPITAL BALTIMORE RANDALLSTOWN Birthplace (State or Foreign Country) 8 Date of Birth Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs **Funeral** (Month, Day, Year) 065-42-3308 **Director** 1 □ M 2 🛛 F 08/24/1926 CANADA 8.5 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 🗆 Yes 2 🄀 No MD BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 9 SADDLE COURT 21208 permit. Page 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 3 ▼ Widowed 4 □ Divorced WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **MERETSKY** LIBBY MERETSKY HARRY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SADDLE COURT, BALTIMORE, MD ARLENE STEEN/DAUGHTER 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP 11/16/2011 TOWSON, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee Mark Lei 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, in any, reading to immediate cause. Enter Underlying Examine Due to for self-echeaquenes of Cause (Disease or injury Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and I for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Pregnant at time of death ed by the a detached 1 g Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 No 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s autopsy performe 1 ☐ Yes 2 ☐ No Yes 2 Z funeral director, 25. Was case referred to edica 26. Place of Death (Check only one) Be examiner? Hospital: Other: မ 1 \sum Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred After atural 5 Pending injury n 24 hours after death.

le Funeral Director: Aft
bletely filled in by the ful Investigation Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practive ner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the F 3 29b. Signature and title

State Registrar 30. Name and address of

31. Date filed (Month, Day, Year)

DHMH 17 Rev 06-2011

(Type, Print)

who completed cause of death (Item 23a)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 201 Physician/ ams 12:37a^M a (-5-Medical 4a. Facility Name (if not institution, give creet and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland Masonic Home Cockeysville Baltimore 8. Date of Birth (Month, Day, Yea Birthplace (State or Foreign Country) 1 Year If Under 24 Hrs. . Social Security Number If Under 7. Age (In vrs. last birthday Funeral Min. Months Days Hours 1 M 2 M 220-09-2054 93 June 6,1918 Director MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director 1 Tes 2 XXo MD Baltimore Cockeysville 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number Funeral 300 International Circle 21030 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XX Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2**XX**No White Specify XX Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Bookkeeper **Automotive** Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Samuel Whiteford Durham Blanche Bavington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Joan Alexander (Daughter) 6418 White Peach Place Columbia, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date matory or other place 1 XXurial 2 Cremation 3 Removal from State William Watters Cem 11/18/11 Jarrettsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility rempon Funeral Home of Dulaney 21. Signature of Funeral Service Licensee 10 West Padonia Road Timonium, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** 0 Sequentially list conditions, Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transi Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death Yes 2 No g 🗌 Unknown s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has by page 2 s autopsy performed? Yes 2 No 1 Yes 2 No certificate within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2X No ည 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of 20649 201 m

Registrar DHMH 17 Rev 7/2009

State

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30. Name and

John W.

300 International Circle, Cockeysville, MD 21030

address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

arks

M.D.

Bowie,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov. 2011 6:35p M Mabel I. Williams Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Joseph Richey Hospice, Baltimore N/A If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Min Hours 217-12-3123 1 □ M 2 🏋 F **Director** 90 MD 09/09/1921 Usual Residence of Decedent show d at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director r 28a-f s notified 1

Yes 2 □ No Anne ARundel Baltimore MD 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ŏ must be r Funeral USA 21225 3040 Ascension Street hours after death 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter ledical Examiner r 11. Marital Status Black, White, etc. by 1 Never Married 2 Married 1 Yes If Yes, Give 21215-0036 1 Yes X No Specify. 3 X Widowed 4 Divorced Completed Black Year or Dates er than "natur , the Medical I 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Laundry Worker Fort Meade 12 is marked other aumatic event, th Be Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Pearl E. Brown Leonard Montgomerv 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health an Important: If item 27 is any injury or other trauonce. 3040 Ascension Street, Baltimore, MD. 21225 Cornell Williams Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11/18/2011 Baltimore, Cedar Hill Cem. 21. Signature of Furieral Service Licenses Estep Brothers Funeral Service 1300 Eutaw Place, Baltimore, Md. 23a. Part Exert the disease, or complications that callsed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 21217 Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trar Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy Vital funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 1 Natural 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 5 Pending Division Tithin 24 hours after death. Investigation ☐ Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) amille Menino, filed (Month, Day, Year) 32. Registrar's Signature 7 2011 Registrar

35

B

Williams

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $1^{M_{\text{Ponth}}} 0 1 - 2^{-3} 1$ 7:21 Mary Jane Roberts Williams Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner rince George's Clinton Southern MD Hospital Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours Min. (Month, Day, Year) 579-44-9085 1 □ M 2XX **Director** Yrs. DC 03-05-1933 78 28a-f show 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 X Yes 2 No MD Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 23a or 10g. Citizen of What Country? Funeral USA 20745 308 Ellsworth Place permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu once. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Completed by 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: Black If Yes, Give 3 Widowed 4 XDivorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Secretary 12th Be 18. Mother's Name (First, Middle, Maiden Sumame) Ellen Cheeseman 17. Father's Name (First, Middle, Last) ပ Clayborne Roberts 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code), $308\ Ellsworth\ Pl.,\ Oxon\ Hill,\ MD\ 20745$ Gail Rowell/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Cedar Hill Cem. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 11-08-201 Suitland, MD 21. Signature of Peral Service Licensee 22. Name and Address of Facility 4111 PA Ave., Suitland, MD Cedar Hill FH, 3a. Part 1. Enter the disease, or complications that each shock, or heart failure. List only one cause on each sed the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is instead or injury Examine Due to (or as a conseque use as the burial-transi that initiated events the Hospital or Attending Physician: The law requires that the death certificate be execresulting in death) Last Due to (or as a cor physician Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Day 5 Other (specify) Pregnant at time of death 2 WNo Yes 9 Unknown Unknown Part II. Other significant coponitions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has After this certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: ၀ 1 Yes 2 - No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Investigation 24 hours after deatl Funeral Director: 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completely f Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signati 29c. License number 29d. Date signed (Month. Day, Year) cause of death (Item 23a) (Type, Print)

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State

Registrar

31. Date filed (Month), Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10 Abel1 Mary Eva Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Callaway Hospice House of St. Mary's Mary' Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Days Months Director 213-56-1956 95 10771771916 Maryland Usual Residence of Decedent or 28a-f show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 X No St. Mary's Leonardtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20811 Hampton Road 20650 United States 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. If Yes Give 3 XWidowed 4 Divorced Completed Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 yrs. College (1-4 or 5+) yrs. Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Thomas Emanuel Higgs Florine Lucretia Bowles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Tennyson/Daughter 24183 Horseshoe Road, Clements, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛚 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Ou<u>r</u> Lady's Cemetery 10/31/2011 Leonardtown, MD of Funeral Service Lice 21. Signat/19 Brinsfield Funeral Home, P.A. Road. Leonardtown, MD 20650 Margaret H. Hicks M01631 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Onset and Death disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached t 1 L Yes 2 L 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 🗌 Yes completed filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: မ 1 Yes 2 No 4 Nursing Home 5 Residence 1 Inpatient 2 I ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 24 hours after death. Funeral Director: A 2 Accident
3 Suicide 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 40055751 30. Name and addres person who completed cause of death (Item 23a) (Type, Print) <u>Jennifér</u> Schmidt 40900 Merchants Lane, Suite 205, Leonardtown, 0. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11:19PM Eleanor T. Bicking 10 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death atth licomico DICE If Under Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🗹 Min. Months Davs Hours (Month, Day, Year)
July 1, Country) Maryland Director 216-16-7978 88 1923 Usual Residence of Decedent show 10b. County the Maryland "natural", or items 23a or 28a-f sho idical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 No Maryland Somerset Princess Anne 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Completed by Funeral 11210 Old Princess Anne Road Apt. 21853 IIS Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in الله S 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cashier Food Service Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ leanor William Jennings Tankersley Thelma A. Webster 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 <u>Jean Harrison POA/Friend</u> 1212 Old Princess Anne Rd., Princess Anne, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Salisbury Crematory /6-36-201 4 ☐ Donation 5 ☐ Other (Specify) ury Crematory: 10-30-2011 Salisbury, Md 22. Name and Address of Facility Hinman Funeral Home PA 21. Signature of Funeral Service Licenses MO0295 11673 Somerset Ave, Princess Anne, Md. 21853 rt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death hock, or heart failure. List only one cause on each line Immediate Cause (Final CARCINOM Physician/ LUNG MALIGNAN disease or condition resulting in death) / Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ in the past 12 months?

1 Yes No
9 Unknown Month Pregnant at time of death ed by the a detached f 9 Unknown After this certificate has been signed by interest director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Hospital HOSPICA မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d Describe how injury occurred work?
1 Yes 2 No iniury 5 Pending Accident Investigation filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 To the I only one 29d. Date signed (Month, Day, Year) 10-27-2011 address of person who completed cause of death (Item 23a) (Type, Print) Ba

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Pear1 Susan Joyner Bowman 2011 3:23 p.₩. November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner St. Mary's Leonardtown 22680 Cedar Lane Court If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 7. Age (In vrs. last birthday) 1 □ M 2 🔀 F Days Hours North Carolina 07/10/1916 Director 237-09-0562 95 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County aţ 10c. City, Town or Location Director must be notified 1 X Yes 2 □ No Leonardtown Maryland St. Mary's 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral United States 20650 22680 Cedar Lane Court items be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Examiner Black, White, etc. 0 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify. "natural", 3 XWidowed 4 ☐ Divorced Completed White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker n and Mental Hyg Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Martha Susan Rice Elisha Lendon Simmons t. Page 1 and 2 should b tment of Health and Mer rtant; If item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lexington Park, MD Dean Court, Thomas W. Joyner, Jr./Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date Department of F Important: If ite any injury or ot once. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/14/2011 | Burlington, NC Pine Hill Cemetery 22. Name and Address of Facility Brinsfield Funeral Home, 21. Si Salur of Funeral Sivice Licence 20650 22955 Hollywood Road, Leonardtown, MD M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final thrive Physician/ Failure disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Demention Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) CAD burial-transi and Due to (or as a consequence of) physician s the burial Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) Hospital or Attending Physician: The law requires that the death 24 hours after death.

Funeral Director: After this certificate has been signed by the atter sted filled in by the funeral director, page 2 should be detached for u in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death Unknown 1 Yes 2 J 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be examiner? 2**X** No Hospital Other: မ 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death

Natural

Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical 29a. Certifier 1 🖰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certification 29d, Date signed (Month, Day, Year) 47066

Registrar

Avani D.

(a) RMe

egistrar's Signatu

22650 Cedar Lane Court, Leonardtown, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shah, M.D.

0 9 2011

8

20650

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Bernice F. . Bodman 2011 4:40pM November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Home St.Mary's Leonardtown Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country 1 □ M 2 🌣 F Hours 0170871913 Director 005-48-5099 98 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maryland St. Mary's California 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 44189 St. Andrews Lane 20619 USA death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Yes 2 No þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed Specify: White 3 X Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N 12 Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Winfred Flinton Maud Willey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Doughty/ Daughter 44189 St. Andrews Lane, California, MD 20619 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 🗷 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan 11/08/2011 Alexandria, Virginia 22. Name and Address of Facility
Mattingley-Gardiner Funeral Home, P.A.
41590 Fenwick Street, Leonardtown, MD 21. Signature of Funeral Service License 20650 Part 1/Enter the disease, or compileations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CAR CLONASC. Physician/ disease or condition Medical resulting in death) as a consequence of Examiner Sequentially list conditions, Examine Due to for as a consequence of. if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): g physician are the burial-t resulting in death) Last Physician/Medical Box 68760 attending physical for use as the b IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 5 Other (specify) ed by the a g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate Yes 2 No 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death.

Funeral Director: After this leted filled in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? Investigation 6 Could not be Accident Sulcide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

State Registrar

Hospital

Medical

29a. Certifier

29b. Signa

ure and title of ce

William D. Boyd,

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

II,

M.D.,

. Registrar's Sign

DHMH 17 Rev 7/2009

completed within 2 the

1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

25365 Point Lookout Road, Leonardtown, MD 20650

29d. Date signed (Month, Day, Year)

		Pleas	se Type or Pri							•	
		For State	State of M	arylar		artment of I <i>rtificate of I</i>	Health and I Death	Mental Hy	0	001	1 06706
		Registrar 1. Decedent's Name (First, Middle, in	Last)			Timeate of I	Jean	2. Date of De		201	3. Time of Death
Physicia Medic			Hien Van	Ви				Month Octob	ber .	28. 201	1 6:48 pm
Examir	ner	4a. Facility Name (if not institution, g	give street and number) Mt. Pisgah 1				r Location of Death Lver Spr		40	c. County of Dea	ntgomery
Funeral					ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Bi		9. Bir	rthplace (State or Foreign
Director		214-41-9513 Usual Residence of Decedent	1 X M 2 □ F	79	Yrs.	Months Days	Hours Min.	(Month, Da	,		vietnam
and show d at	for	10a. State 10b. County		10c. Cit	y, Town or Lo	ocation	1	1 02///	,	<u> </u>	10d. Inside City Limits
Mary 28a-f	Director		tgomery				Silver S	oring			1 ☐ Yes 2 🛛 No
vith the 23a or st be I	ral	10e. Street and Number	t. Pisgah Ro	ad		10f. Zip Code	20903		10g. C	itizen of What C	ountry? etnam
death v items ier mu	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		S. 13.	Was Decedent of H	lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	-	14. Race - Ame	erican Indian,
after o	by	1 ☐ Never Married 2 🗶 Marrie 3 ☐ Widowed 4 ☐ Divorced	1 Yes 2 X If Yes, Give	No	- 1	1 ☐ Yes 2 🗓 No		o r noun, oto.,		Black, White Specify:	te, etc. Asian
hours natura dical E	Completed	15. Decedent' (Specify only highest			16a. Dece	dent's Usual Occur	pation during most of wor	deim —	16b. l	Kind of Business	
thin 72 ine. than " ie Med	Som C	Elementary/Secondary (0-12)	College (1-4 or 5	ō+)	life. D	OO NOT use retired;		J	1 11	.S. Gov	a tuma u t
led wit Hygie other ent, th	Be	17. Father's Name (First, Middle, Las	<u>4</u>		1 11	wesnya	ion Office 18. Mother's Nar				Deranera
ld be fi Menta arked atic ev	은		Don Van Bi	ii	,			Chi	лу Т	hi Le	
2 shou h and 7 is m traum		19a. Informant's Name/Relationship	, , , ,		1	-	and Number or Ru				
f Healt f Healt item 2		Bich Thuy Bui - 20a. Method of Disposition			Place of Dispo	osition (Name of		Date	T	ocation - City o	ryland 20903 r Town, State
Page nent or ant: If It ary or		1 💹 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				matory or other pla Mem. Par		04/2011	Ro	ckville.	, Maryland
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Lic	ensee	10-00	, 2:	2. Name and Addre	ess of Facility Hi	nes-Rina	aldi	Funera	l Home. Inc.
452 6 0		23a. Part 1. Enter the disease, or co	omplications that caused	the deat						ver Spr	ing, MD 20904
Physician/		shock, or heart failure. List onl Immediate Cause (Final disease or condition	y one cause on each line	€.			of the Li				Interval Between Onset and Death
Medical Examiner		resulting in death)	Due to (or as	a conseq	uence of):	vicetionia_	on the L	ang			
	Jer	Sequentially list conditions, if any, leading to immediate	b. Due to (or as	a consequ	uence of):		·				
and Aransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c		,					_	
an aria	<u>a</u>	resulting in death) Last	Due to (or as	a consequ	uence of):						
icate b i physics is the b	edic	*	d								
ath certificate be attending physic for use as the b	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live Birth			☐ Ectopic pregnan	cv			23d. Date of de	əlivery
e death the att	ysici	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown			Other (specify)	-,			Month	Day Year
requires that the de been signed by the s should be detached	by Ph	Part II. Other significant conditions	s contributing to death b	ut not res	ulting in the u	underlying cause gi	ven in Part I.	23e. Did	tobacco	use contribute t	o the cause of death?
quires en sign	ted b	Coronary Arte	ry Disease					1 🕱	Yes 2	□ No 3 □ F	Probably 4 🗌 Unknown
law rec nas ber e 2 shc	Completed							24a. Was	psy	prior to	utopsy findings available completion of cause of
sician: The law I certificate has the lirector, page 2 s		25. Was case referred to medical				00. 5		1 Tyes	ormed? 2 X N	death?	es 2 🗆 No
ysician: is certific director,	To Be	examiner? 1 \(\sum \) Yes 2 \(\overline{\chi} \) No	Hospital:	ent 2 🗆	ER/Outpatie	nt 3 DOA Oth	lace of Death (Checer:		idence	6 ☐ Other (Spe	cify)
ing Phys ffer this uneral di		27. Manner of Death 1 ↑ Natural 5 □ Pending	28a. Date of inju (Month, Day	ry	28b. Time or injury	f 28c. Injur	y at </td <td>28d. Describe</td> <td></td> <td></td> <td></td>	28d. Describe			
Attend death ctor: A	Certificate:	2 Accident Investigat 3 Suicide 6 Could no	ot be 280 Place of Inju	ırv - At ho	me. farm. str	M 1 L	Yes 2 No	28f. Location (Street ar	nd Number or Ru	ural Route Number,
s after s after al Director		4 ☐ Homicide determine	building, etc			001, 140101 ,, 011100		City or To			War Hodeo Harrison,
the Hospital or Attending in 24 hours after death. The Funeral Director: After pletely filled in by the funer	Medical	(Check 2 Medical Exa	hysician: To the best of aminer: On the basis of e	xaminatio	and/or inves	tigation, in my opini	on, death occurred a	at the time, date	and place	e, and due to the	cause(s) and manner stated.
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the bu	Me	only one) 3 Certifying N 29b. Signature and title of certifier	lurse Practitioner: To the	e best of r	ny knowledge	, death occurred at 29c. Licens	the time, date and p	lace, and due to	the caus	e(s) and manner ate signed (Mont	as stated.
->-40		>	11	MD		D3	54486				31,2011
		30. Name and address of person wh				,	4210	T = L :	. T	ub 11	uland 00010
Stat	te	Ton T. Chieu, 31. Date filed (Month, Day, Year)	\$2. Registra	NEW ar's Sign	ture	wre Aven	ue, #310	, iarom	u ra	rr, mar	yxana 20912
Registra		NOV 0 2 20	11 /2	. 1.	MAN	LA COLON					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Roger Francis Carroll, Jr. Octob 500M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SAisbury

If Under 1 Year If Under

1 Days Hours Peninsula Kegional Medical Center Wicemico 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months (Month, Day, Year) 86 **Director** 026-14-8092 1 **X** M 2 □ F Jan. 1, 1925 Ma. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f sho the Maryland notified at Director MD. Somerset 1 Yes 2 X No Princess Anne r items 23a or iner must be n 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 11485 Dryden Road United States 21853 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status er than "natural", or ite the Medical Examiner Armed Forces?

1 X Yes 2 No 1943
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 Yes 2 No Specify. White Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) F.B.I. Agent Law Enforcement Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ent of Health and Mental Hat: If item 27 is marked ot y or other traumatic even Roger Francis Carroll ၉ Clara Shaughnessy Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11485 Dryden Road, Princess Anne, Md. 21853 Madge Carroll Wife altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Tremation 3 Removal from State Department Important: If any injury or Salisbury Crematory 1/0-3/-2011 4 Donation 5 Other (Specify) Salisbury, MD 21. Sign / re of Funeral Service Licenses 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave., Princess Anne, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ate Cause (Final Physician/ distre or conum re ting in death) e or condition Medical Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate Cause (Disease or injury that initiated events the Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the attending IF FEMALE asn 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Yes 2 No 1 ☐ Yes ≥ L 9 ☐ Unknown 9 Unknown detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be 1 Yes 2 No 3 Probably 4 Unknown been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 Yes 2 No completely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Na Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No 1 X Natural injury 5 Pending Investigation Accident 24 hours after deatl Funeral Director: 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 🧏 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the within To the 2 e of death (Item 23a) (Type, Print) 30. Name and Carroll 100 E. Md 21801

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

OCT 31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Marv Janice Cooper November 2011 3:25 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's Nursing Center Leonardtown St. Mary's 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1 □ M 2 🕅 F Days (Month, Day, Year) 06/25/192 Director 216-16-4442 90 Mary Tand Usual Residence of Decedent show 10a. State 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director r 28a-f sl notified 1 🗌 Yes 2 ី No Maryland St. Mary's Leonardtown ò 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral 41211 Medleys Neck Road 20650 United States "natural", or items and 2 should be filed within 72 hours after death 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceuen . ____ Armed Forces? 1 ☐ Yes 2 🔀 No 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 Divorced Completed Specify: White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home and Mental Hygie is marked other event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည James Douglas Dunbar traumatic Mary Lillian Armsworthy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 41211 Medleys Neck Road, Leonardtown, MD Patricia Goin/Daughter altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Charles Memorial Cem 11/08/2011 Leonardtown, MD Signature of Funeral Service Licensee 22. Name and Address of Facility mel Brinsfield Funeral Home, P.A. M01403 Danielle Ward Hollywood Road, Leonardtown, 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami -tran and resulting in death) Last Due to (or as a consequence of) burial physician Physician/Medical certificate be P.O. Box 68760 the attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year the 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has performed? Yes 2 No 2 X No certificate 1 🗌 Yes Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 XNo Hospital Other: 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA this 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural (Month, Day, Year) 5 Pending injury work death. Accident M 1 Yes 2 🗌 No Investigation Funeral Director: eted filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Aractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature nd title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (4) RME <u>William D.</u> Boyd, 25365 Point Lookout Road, Leonardtown, MD M.D. 31. Date filed (Month, Day, State NOV 0 9 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36802 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 8:30 a.m.M Joseph Clement Cheseldine November Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 37302 River Springs_Road St. Mary's Avenue 9. Birthplace (State or Foreign Country) Maryland Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days 1 👿 M 2 🗆 F Months Hours Min. 07/16/1916 Director 219-16-0582 Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10c. City, Town or Location other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland St. Mary's Avenue 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral 23a 37302 River Springs Road 20609 United States or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian Armed Forces Black, White, etc. þ 1 Never Married 2 X Married 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify "natural", Completed 3 Widowed 4 Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 12 Seafood Waterman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Richard Benjamin Cheseldine Agnes Gwenette Bowles and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) .. Page 1 and 2 sl tment of Health *s* **tant: If item 27** i <u>Mary Marguerite Cheseldine/Wife</u> 37302 River Springs Road, Avenue, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Charles Memorial Cem 11/08/2011 Leonardtown, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease Physician Coronary disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 1 Yes 2 L P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires t 24 hours after death. Funeral Director; After this certificate has been sign disease Records, 1 Yes 2 No 3 Probably 4 Unknown in by the funeral director, page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? Yes 2 No 1 Yes 2 No **Division of Vital** Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 $\boxed{\mathbf{X}}$ Residence 6 \square Other (Specify) Hospital: ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a completed filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the ! Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

)eme State

Thomas M. Wilkinson,

23140 Moakley Street, Leonardtown, MD M.D.

attending

31. Date filed (Month, Day, Year, NOA O R

30. Name and address of person who completed cause of death (frem 23a) (Type, Print)

Registrar

D0055682

Joanne Howells Cannon

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	State of Maryland / I	Department of H	Health and Men	tal Hygiene

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		1- For State Certificate of Death Reg. No. 1. Decreter's Name (First Middle Last) 2. Date of Death 3. Til									1 0000					
Physicia	n/	1. Decedent's Name (Fir	Decedent's Name (First, Middle,Last) Joanne Howells Cannon 2. Date of Death Month Day October 28, 2011											ear	3. Time of Death	
Medical Examin	ıer	Joanne I	Howell	s Canno	on							tober 28			1125 hrs	
		4a. Facility Name (if not 1200 Brunswick		give street and	number)			. City, Towr Arnold	, or Loc	ation of Dear	th		4c. County			
Funeral	╗	5. Social Security Numb	er 6.	Sex	7. Age (I	n yrs. last b	irthday)	If Under 1		f Under 24Hi	rs. 8. C	ate of Birth	(MM/DD/YY)	(Y) 9. Birt	pplace (State or	
Director		577-56-344		_м 2Дг	7	72	Yrs.	Months	Days	Hours Mi	in. 06	5/22/	1939	Cou	polace (State or District of Intry Columbia	
any	\perp	Usual Residence of Dec 10a, State 10b.	County		110	c. City. Tow	n or Location								10d, Inside City Limits	
. .	ō	MD A	Anne A	rundel			Arnold	l							1 Yes 2 No	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "satural", or items 23a or 28a-f sho satic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 1200 Brur		Court				10f. Zip Coo 21	₀₁₂			10	g. Citizen of V USA	Vhat Cour	try?	
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after dea				ed If Yes, Give Y		No	1 Y	es 2X	No st	pecify:			Specify	. N	hite	
nours :	8	15. Decedent's Educat		only highest g		eted) 16a	. Decedent's			(Give kind of NOT use re		one	16b. Kind of E	Business/l	ndustry	
136 hin 72 t e. than "1	Completed by	Elementary/Secondar	ry (0-12)	College 5	(1-4 or 5+)			jister			,		Heal	thcar	e	
21215-0036 uld be filed within 77 Mental Hygiene. marked other than event, the Medical	ភ្ញុ	17. Father's Name (First	t, Middle, La	st)					18.N	Nother's Nam	ne (First,	Middle, M	aiden Surnam	ne)		
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D 21 hould is ma	의	19a. Informant's Name/F	•		/ =		-	•					per, City or To		Zip Code)	
≥ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	-	Paul Jeff1 20a. Method of Dispositi		eviaser	/ Son		904 Will of Disposition		_		Date		20c. Location		Town, State	
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Baltimo permit. Pago Department Important: injury or ot	ł	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park									ole Di	maral Homa				
E E De CO	-	495 Ritchie Hwy, Severna Park								rk, M	D 21146					
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Medical Examiner	İ	Immediate Cause (Final or condition resulting in		a. Contact (f Chest								Death	
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To the Hospital within 24 hours To the Funeral completely filled	Medical			ner:On the bas and manne	is of examin											
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Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

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	-	For State Registrar	ate of Ma	ryiana /		ırımen tificate			and iv	lental Hygi		201	1 3	36804
		Decedent's Name (First, Middle, Last)								2. Date of Death	1			me of Death
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Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last b	birthday)	If Under	1 Year	If Under		8. Date of Birth		g. Bii	rthplace (St	tate or Foreign
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be file ental I rked o rc eve	2	William Lee Ussery								Morris	alueri Surri	arriej		
should and M is mai		19a. Informant's Name/Relationship (Type, Prin	nt)	1	19b. Mailin	g Address	(Street a	nd Numbe	er or Rura	l Route Number,	City or Tow	n, State, Z	ip Code)	
and 2 s tealth sm 27 her tra		Katherine Henshaw/Da	aughter					Lake		ace, Boy				
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mit, Pa bartme bortan ' injun;	ŀ	4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee	D	Metro	22	Name and	d Addres	s of Facilit	20 y	± ±	lexar		, VA	
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		30. Name and address of person who complet Lynn Byars, MD 8	e cause of dea 901 Wis				Bet	hesda	, MD	20889	(WRNI	(MC)		
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Registra	ır	NOV 0 2 2011	32 Registrar	, B.	199	A day								

11-08536 John Chapman

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2011 36805

			1- For State Registrar	Certificate		ina montai n		j. No.	. 0000
M = -11 =	Physic	ian/	Decedent's Name (First, Middle,Last)			-	2. Date of Death		3. Time of Death
, In JuliC	al Exam	iner	John Ryan Chapman 4a. Facility Name (if not institution, give street and nu		14.00 7.00	and the state of Barrell	Month November		1702 hrs
			Atlantic General Hospital	mber)	Berlin	or Location of Death	1	4c. County of Death Worcester	
	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday		ear If Under 24Hrs	s. 8. Date of Birth	(MM/DD/YYYY) 9. Birt	hplace (State or
	Director		212-29-5411 1XM 2 F			ays Hours Min		Foreign	n unto ()
			Usual Residence of Decedent		113.		July 27	7, 1987	Maryland
	'any	l	10a. State 10b. County	10c. City, Town or Lo	cation				10d. Inside City Limits
	and show	b	Maryland Worcester		Ocean	City			1 Yes 2 No
	Maryl 28a-1	할	10e. Street and Number		10f. Zip Code		100	g. Citizen of What Coun	try?
	h the	ā	245 Robin Drive #102			21842		United S	tates
	death with the Maryland or items 23a or 28a-f sho must be notified at once.	Funeral Director	11. Marital Status 1 X Never Married 2 Married Armed For	orces?		Hispanic Origin? (Sp an, Mexican, Puerto		14. Race - Americ White, etc.	can Indian, Black,
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5	filed within 72 hours after death with the Maryland al Hygeine Historian Laterals, or items 23a or 28a-f she do ther than "natural", or items 23a or 28a-f she i, the Medical Examiner must be notified at once	ပ္ဆိ	17. Father's Name (First, Middle, Last)			18.Mother's Name			
21215-0036	en rk	To Be	Michael Rene Guerrero 19a. Informant's Name/Relationship (Type, Print)	19h Mai	iling Address (Str	Darlene	Chapmar	1 er, City or Town, State,	Zin Code)
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e,	l and Health item		20a. Method of Disposition		position (Name of o	cemetery,	Date Date	20c. Location - City or	aryland 20850 Town, State
по	ages ant of nt: If		1 X Burial 2 Cremation 3 Removal from 4 Donation 5 Other Specify:	om State Gate Of Hea	other place)	Nove	mber 18,	Cilvon Con	ing, Maryland
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760,	cate b physic he bu	Me.		outcome of pregnancy		_		23d. Date of delivery	
89	certifi nding se as t	ian	23b. Was decedent pregnant in the past 12 months?	ant at time of death		Ectopic pregna	incy	Month D	ay Year
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ည	he law ate has age 2 s	Completed					perform	ed? death?	
<u>18</u>	ysician: The la his certificate ha director, page 2	BeC	25. Was case referred to medical		26.Pla	ce of Death (Check	only one)		
Division of Vital Records,	'hysic this c	To E	TW Tes Z NO	npatient 2 🗹 ER/Outpatie	ent 3 DOA	Other Nursin	g Home 5 R	esidence 6 Other:	
o	ding Ph After ti funeral			of Injury 28b. Time of Day,Year)		jury at Work?	28d. Describe ho	w injury occurred	
Sio	Atten death ector:	cati	2 Accident Investigation	At lease of lease of		Yes 2 No	204 1	and Marshar and David	al Day de Number City
j <u>v</u> i	s after al Direction	Certification:	Suicide Could not be determined	e of Injury - At home, farm, si	treet, factory, office	bullaing, etc.	or Town, Sta	eet and Number or Rur te)	al Route Number, City
	To the Hospital or Attending Physician: The law requires that the death certific within 24 death death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as t		29a. Certifier 1 Certified Physiology To the bea	of my knowledge death oc	curred at the time	date and place, and	due to the cause/	s) and manner as state	d.
	o the lithin 2 o the l	Medical	one) 2 Medical Examinar: On the basis of and manner st	f examination and/or investi			· ·		
	£ ₹ ₹	Æ	29b. Signature and title of certifier	uicu.	29c. Licer	nse number	1	29d. Date signed (Mon	th, Day, Year)
	and		(I anderbe eur)		0.0	M.E.		November 15, 20	11
LP			30. Name and address of person who completed caus	, ,					
10				Examiner 900 W.	Baltimore Stre	et, Baltimore, N	MD 21223		
	St Regis	ate	31. Date fled (Month, Day Year) 32. Re	gistrar's Signature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36806 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Cecelia Fenwick 2011 10:30 a.m. Susan November Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St. Mary's 40801 South 40 Drive Leonardtown 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth 1 🗆 M 2 🗶 F Months Days Director 06/29/1971 215-02-2738 Washington, DC 40 Usual Residence of Decedent 28a-f show 10b. County event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Yes 2 X No Maryland St. Mary's Leonardtown ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a 40801 South 40 Drive 20650 United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 XNo 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. "natural", 3 Widowed 4 Divorced Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Editorial Assistant U.S.Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Vincent Ralph Tayman, Sr. Mildred Cecelia Windsor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important; If item 27 is any injury or other trau John K. Fenwick/Husband 40801 South 40 Drive, Leonardtown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Aloysius Cemetery 11/07/2011 Leonardtown, MD 21. Signature Frieral Service Licensee
Edward N. Brinsfreid, Brinsfield Funeral Home, P.A. Road, Leonardtown, MD 20650 M0005 22955 Hollywood Road, Leonardtown, MD Jr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on eag Immediate Cause (Final Onset and Death -Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Litter Underlying Cause (Disease or iinjury Due to (or as a consequence of) requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a d be detached f 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law Jas autopsy performed? Yes 2 No certificate 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Tes 2 NiNo ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b, Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation upleted filled in by the 3 Suicide 4 Homicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (10) Rme Jennifer Schmidt, 40900 Merchants Lane, Leonardtown, MD D.O. 20650 31. Date filed (Month, Day, Year) State

Registrar

NOV 07

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3680 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 5:47 p.m[™] 2011 Lillian Garner November Mary Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's <u>Leonardtown</u> St. Mary's Hospital 8. Date of Birth If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 9. Birthplace (State or Foreign Social Security Number Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🗓 F Days 11/06/1939 Mary Tand Yrs. Director 212-38-3308 Usual Residence of Decedent show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🛛 No St. Mary's <u>Maryland</u> Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 20653 United States 22167 Donaldson Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Divorced 4 Divorced **Black** Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Elizabeth J. Garner George Toney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21218 1623 East 29th Street, Baltimore, MD Thomas A. Mason/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a, Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Immaculate Heart Cem 11/12/2011 Lexington Park, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign cure of Everal Service Licen Edward N. Brinsfield 22955 Hollywood Road, Leonardtown, MD M00052 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Winset and D Immediate Cause (Final Pnysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 Unknown 1 Yes 2 No Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has 2 🗌 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Be (Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tyes 1 Inpatient 2 R/Outpatient 3 DOA မ 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director, and completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner To the best of my knowledge, death, contend at the time, date and state, and due to only one

State Registrar

(H) Rme

29b. Signature a

who completed cause of death (Item 23a) (Type, Print)

Registrar's Signati

person who completed ca

29d. Date signed (Month, Day, Year)

POINT LOOKOUT RD Leonardtown MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland Registrar	/ Depa <i>Cert</i>	rtment of H	ealth and Neath		giene 2	011	36808
			Decedent's Name (First, Middle, Last)				2. Date of De	ath		3. Time of Death
	Physicia Medic		Margaret Jean Gordon				Month Novemb	per 5,	2011 1	0:50 a.₩.
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death			ty of Death	
	Funeral		Solomons Nursing Center 5. Social Security Number 6. Sex 7. Age (In yrs. last		Solomons If Under 1 Year	If Under 24 Hrs.	8. Date of Bin	Calv		e (State or Foreign
	Director		_569-18-1377 1□M2XIF 94		Months Days	Hours Min.	(Month, Da 11/19/	1916	Calif	ornia
	nd now at	١	Usual Residence of Decedent 10a. State 10b. County 10c. City. T	Town or Loca	ation		-		104	Inside City Limits
	larylar 3a-fsl ified	Director	Maryland Calvert Lusby							1 ☐ Yes 2 X No
	the N a or 28	Ē	10e. Street and Number		10f. Zip Code			10g. Citizen of	f What Country	?
	h with ns 23; nust l	Funeral	429 Port Drive		20657			United	States	
	r deat or iten iner r		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married	13. W If	as Decedent of His Yes, specify Cuban	spanic Origin? (Spe n, Mexican, Puerto	ecify Yes or No- Rican, etc.)		ace - American ack, White, etc.	Indian,
036	be filed within 72 hours after death with the Maryland that Hygiene 4 set other than "natural", or items 23a or 28a-f sho ked other than "natural", or items 23a or 28a-f sho ic event, the Medical Examiner must be notified at	Completed by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give 1 Year or Dates.	1	☐ Yes 2 🏻 No	Specify:		Specin	^{fy:} Whit	P
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g S	led wi Hygie other ent, ti	Be (17. Father's Name (First, Middle, Last)	egai	Secretary	y 18. Mother's Nam	e (First, Middle,		Govern	allent
/Jan	d be fi Jental Irked Itic ev	우	Clayton Hestman			Mary Ker			,	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland than d Mental Hygiene. Z7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Print)	19b. Mailinç	g Address (Street ar	nd Number or Rura	al Route Numbe	r, City or Town,	State, Zip Coo	(e)
	1 and 2 s of Health item 27 other tra				ort Drive			0657	O'1	0
Baltımore,	Page 1 nent of ant: If it ury or o		1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State cem-	etery, crema	ition (Name of atory or other place	9)	Date		- City or Town	
ᆵ	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	sfield 22.	1-Echols Name and Address	- C F 104 -				
ñ	a m Per la		Naville Ward Danielle Ward		955 Holl	Br:	insfield ad, Leon	l Funer nardtow	al Home n, MD	20650
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	be executed sician and burial-transi	dical Examiner	resulting in death) Last Due to (or as a consequence	ce ot):						
00/	requires that the deam certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	ledic	d							
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DIVISION	r Atte ter de irecto	ertif	3 ☐ Suicide 4 ☐ Homicide determined 28e. Place of Injury - At home building, etc. (Specify)	, farm, stree	et, factory, office		28f. Location (S City or Tov		ber or Rural Ro	oute Number,
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=	to one nospital or Attended Priysican: The law within 24 hours after death. To the Funeral Director After this certificate has completed filled in by the funeral director, page 2 s	Medical	29a. Certifier (Check Check Certifying Nume Fractioner: Of the basis of examination and Certifying Nume Fractioner: Of the basis of examination and Certifying Nume Fractioner: Of the basis of examination and Certifying Nume Fractioner: Of the basis of examination and Certifying Nume Fractioner: Of the basis of examination and Certifying Physician: To the best of my knowledge and the basis of examination and Certifying Physician: To the basis of examination and Cer	nd/or investig	gation, in my opinior	n, death occurred a	the time, date a	and place, and c	lue to the cause	
i	No the within to the complete	2	29b. Signature and title of certifier		29c. License				ied (Month, Da)	
			Malera, MAS		1000	147/5	3	Morre	mk Dr	7,2011
2	01010		30. Name and address of passes who completed cause of death (Item 23	a) (Type, Prj	int) 1	100	2 11.1	Maria	of week	10/57
) }	UNUL Stat	e	31. Date filed (Month, Day Year) 8 2011 32. Jegistrar's Signature	201	WIN FIN	VI PAMOL	11900	WANH	17100	NI 15
	Registra	ar	31. Date filed (Month, Day, Year) 8 2011	1. 19	all					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2011 Bettie Gatton October Ann 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 23160 Aloysius Court St. Mary's Leonardtown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Months Washington, DC 220-28-6087 79 1932 April. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland St.Mary's Leonardtown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23160 Aloysius Court 20650 USA . Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates White 15. Decedent's Education 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Board of Education Cafeteria Assistant Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Emory Carrico Maria Roberta Canter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41515 Reins Court, Leonardtown, MD 20650 Janet Lynn Scully/ Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
St.Mary's Bryantown 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 11/02/2011 Bryantown, MD 20617 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. 41590 Fenwick Street, Leonardtown, MD 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate

Ph, sician/ Medical **Examiner** Medical Certificate: To Be Completed by Physician/Medical Examine

Physician/

Medical

Director

Funeral

Completed by

Be

10a. State

Examiner

Funeral

Director

23a or 28a-f show

"natural", or items 23a or 28a-f sho edical Examiner must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Mericone.

ohysician and the burial-transit attending physician use for ed by the a within 24 hours a er death.

To the Funeral Director After this certificate has been signed 's completed filled in by the funeral director, page 2 should be del

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

shock, or heart failure. List only		interval Between
Immediate Cause (Final disease or condition	HELTIT MYELDID LEUKENIA (Secondary)	1 Onset and Death
resulting in death)	a.	TI THOW THE
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Sequentially list conditions,	h .	
if any, leading to immediate	Due to (or as a consequence oi).	- 10
cause. Enter Underlying Cause (Disease or iinjury		
that initiated events	C	
resulting in death) Last	Due to (or as a consequence of):	
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IF FEMALE:		
23b. Was decedent pregnant	23c. If yes, outcome of pregnancy	e of delivery
in the past 12 months?	1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) Mon	,
1 Yes 2 No 9 Unknown	9 Unknown	
9 L Unknown		
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contri	oute to the cause of death?
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	1 L Yes 2-2 No	3 Probably 4 Unknown
	24a, Was an 24b, W	ere autopsy findings available
·		rior to completion of cause of eath?
		Yes 2 No
25. Was case referred to medical	26. Place of Death (Check only one)	
examiner?	Hospital: Other:	
	1 L Inpatient 2 L ER/Outpatient 3 L DOA 4 L Nursing Home 5 L Residence 6 L Other	(Specify)
27. Manner of Death	28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. injury at work? 28d. Describe how injury occurred work?	Ė
1 Natural 5 ☐ Pending 2 ☐ Accident Investigatio		
3 ☐ Suicide 6 ☐ Could not b	ha ————————————————————————————————————	
4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number City or Town, State)	or Rural Route Number,
29a. Certifier 1 Certifying Phy	ysician. To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner	r as stated
(Check 2 Medical Exam	niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due	to the cause(s) and manner stated.
only one) 3 Certifying Nur	rse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mar	ner as stated.
29b. Signature and title of	29c. License number 29d. Date signed	(Month, Day, Year)
	Ames Kun (1) 10/00/11 /2/19	4/2.11
She !	- (AMIR KHAN, M.S) 068846 10/3	1/00/1

POINT LODKOUT Rd.

25500

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KHAN, M.D

AMIR

31. Date filed (Month, Day, Year) 0CT 3 1 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last GUSHORN, SR 0913 M Physician/ Month ONALD Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Director 69 220-38-3599 9/5/1942 Maryland 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 🗓 No Temple Hills Maryland Prince George's 10e. Street and Numbe 10f, Zip Code 10g, Citizen of What Country? Funeral USA 20748 4527 Deer Park Drive hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Narried ð Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Year or Dates. 1960-64 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry should be filed within 72 h and Mental Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Telecommunications 12th Installer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Department of Health and Menta Important: If item 27 is marked any injury or other treesones. Mary Connick Samuel Goshorn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4527 Deer Park Drive, Temple Hills, MD 20748 Gretta T. Goshorn/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 11/5/11 Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signatur of uneral Service Ocen 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betwe Onset and Death Immediate Cause (Final MALIGNANT MELANOMA METASTATI Ph_sician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or injury and that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the t IF FEMALE ase i fyes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? for Month Dav Year Pregnant at time of death signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2- No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 124 hours after death.
 Funeral Director: After this certificate has b. autopsy performed 1 🗆 Yes 2 🗆 No 1 Yes 2 No in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: No 1- Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, ပ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 Natural 5 Pending 2 🗆 No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 To the only one) 29b. Signature and title of certifie 302011 Name and address of person who completed cause of death (Item 23a) (Type,

Registrar

32. Registrar's Signature

NOV 0 1 201

FENSE HWY ANNAPOLIS M DZIYOI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Paul	Henrey Ho	older	1- For State Registrar	State of Marylar		artment of <i>rtificate of</i>		and Men	tal Hy		eg. No. 2	n i	1 2601
	Physic		1. Decedent's Name (First, Mid			_				2. Date of Dea	th	U 1	3. Time of Death
VIEC	ical Exam	iner	Paul Henry 4a. Facility Name (if not institut		nher)		4b. City, Town,	or Location o	of Death	Month October 2	6, 2011 4c. County o		1201 hrs
			Frederick Memorial I		1001)		Frederick		n Death		Frederick		
	Funeral		5. Social Security Number	6. Sex 7	7. Age (In yrs. I	ast birthday)	If Under 1 Y		r 24Hrs.	8. Date of Bir	th(MM/DD/YYYY)	9. Bir Foreig	
	Director	ĺ	216-78-7625	1 M 2 F	50	Yrs		ays Hours	Min.	02/19/	1961		untry) MD
	#0 A		Usual Residence of Decedent 10a. State 10b. County	,	10c. City	. Town or Locat	ion			-			10d. Inside City Limits
		_	MD Fred	erisk	1	nswick							1 X Yes 2 No
	farylar 28a-f.s	Director	10e. Street end Number	21 1-31	1 51 0	THO WITCH	10f. Zip Code	9		1	0g. Citizen of Wha	at Cour	ntry?
	rith the Maryland 123a or 28a-f sho 2 notified at ooce.	늅	513 West Poto	mac Street			21716	6			USA		
	th with terms 2 at be n	Funeral	11. Marital Status 1 Never Married 2 X	12. Was Dece			s Decedent of es, specify Cub				- 14, Race - White,		can Indian, Black,
	ter dea ", or it			1 X Yes ivorced If Yes, Give Year or Dates:	2	1	Yes 2 🛛 I	No specify:			Specify: V	Jhi t	tρ
	ours af	d by	15. Decedent's Education (Sp	ecify only highest grade	completed)	16a. Deceden	t's Usual Occu	pation (Give			16b. Kind of Bus		
•	5-UUS6 lled within 72 hours a Hygiene. I other than "natura the Medical Exami	Completed	Elementary/Secondary (0-12		4 or 5+)		ost of working I			ed)			
Š	within giene.	E	17. Father's Name (First, Middle	2		Medic	al Tech			Eiret Middle !	US Navy Maiden Surname)	/	-
2	41415-UUSB wald be filed within 7 Mental Hygiene. marked other than c event, the Medica	Bec	James Edward							uline F			
	 MIJ 21213-UU30 and 2 should be filed within 72 hours after death with the Maryland eath and Mental Hygiene. In marked other than "matural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once 	P	19a. Informant's Name/Relation	iship (Type, Print)		200		reet and Num	ber or Ru	ıral Route Nun	nber, City or Town		
	e, ML 1 and 2 sho Health and item 27 is r traumati		Barbara Anne	Holder - Wi		513 Place of Dispos				Brunsw	ick, MD		
-			1 X Burial 2 Cremation	_	n State	crematory or oth	ner place)	"					. =
3	Dailimore permit. Pages 1 Department of F Important: If injury or other		4 Donation 5 Other S 21. Signature of Funeral Service	Specify: e Licensee	Bro	WNSV1 1	e Heigh	1ts Ce l ess of Facility			1 Browns		
å	Pen grilli		7144 0		M009	70			Laci				rton Funeral
F	Physician		23a. Part I. Enter the disease, of failure. List only one cause	r complications that cau e on each line.	used the death	. Do not enter th	ne mode of dyir	ng, such as ca	ardiac or i	respiratory arre	est, shock, or hea	rt	Approximate Interval Between Onset and
	Examiner	8 11	Immediate Cause (Final diseas or condition resulting in death)				ovascular D	Disease					Death
			Sequentially list conditions,	Due to (or as a c	onsequence o	1):							
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c	e be ex ysician burial		UNPENDED	AMENDED									
276	rtificat ing ph as the	an/N	IF FEMALE; 23b. Was decedent pregnant in t past 12 months?		utcome of pregi th		al death	3 Ectopic	pregnan	су	23d. Date of d Month		y Day Year
200 C87C	leath certificate attending phy for use as the b	Physician/M		4 Pregnar	nt at time of de	ath 5 Oth	ner (Specify)						
	the d		Part II. Other significant condi		11.4	esulting in the u	nderlying cause	e given in Pa	rt I.	23e. Did to	bacco use contrib	ute to	the cause of death?
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of Vital Bocorde	The law icate has page 2 si	Eo								perfor		eath? ✔ Ye	s 2 No
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5		tion	1 ✓ Natural 5 Pen	(Month, D)ay,Year)		` ' _	Yes 2	- 1		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-	
Divieion	or Atteorather Director:	ertification:		estigation 28e. Place	of Injury - At ho	ome, farm, stree	t, factory, office	e building, etc	. 2			or Ru	ral Route Number, City
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	To To Com	Medi	29b. Signature and title of certifi	and manner stat	ted.			nse number		,	29d. Date signed		
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	Š		30. Name and address of persor	·	•								
		لِي	Melissa Brassell, MD					Street, Ba	ltimore	e, MD 2122	3		
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Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed	within 24 hours after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completed filled in by the funeral director, page 2 should be detached for use as the burial-transit
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	+	Registrar 1. Decedent's Name	(First, Middle, I	Last)	· · ·		Timodio or E	JOG111	2. Date of Dea		UII	3. Time of Death
Physicia Medic		Nancy N	Marie	Hayden					October	31°, 20	01 ^{Year}	9:55 a.m.
Examin	er		_	ive street and number)				Location of Death			ty of Death	
Funeral		5. Social Security Nu		f St. Mary 7. A		ast birthday,		If Under 24 Hrs.	8. Date of Birth	1	Mary s	place (State or Foreign
Director		217-42-45		1 □ M 2 🂢 F	66	Yrs.	Months Days	Hours Min.	(Month, Day 02/03/1	945	Mary	land
and show at	١	Usual Residence of E 10a. State	Decedent 10b. County	<u></u>	10c. Cit	y, Town or L	ocation.				1	10d. Inside City Limits
Maryle 28a-f otified	Funeral Director	Maryland	St. Ma	ry's	Va1	ley L	ee					1 🗆 Yes 2 ื No
th the	alDi	10e. Street and Numl	ber				10f. Zip Code			10g. Citizen of	What Cour	ntry?
ath wi	une	45603 Dra	ayden R	oad 12, Was Decedent	Ever in 11.9	3 113	20692 . Was Decedent of Hi	ispanic Origin? (Spe		Jnited_	State	
ter des	by F	1 Never Marrie	ed 2 🗆 Marrie	d Armed Forces	No	J. 10	If Yes, specify Cuba	n, Mexican, Puerto			ack, White,	
urs afi tural", al Exa	ted	3 X Widowed 4		If Yes, Give Year or Dates.			1 ☐ Yes 2 🔀 No			Specif	Whi	te
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uld be I Meni narke natic	ř	Herman O						Thelma M				
2 sho Ith and 27 is r traun		19a. Informant's Nan					ling Address (Street a					
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Page nent c ant: If ury or		1 🔀 Burial 2 □ 4 □ Donation	Cremation 3 \Box Other (Spe	Removal from State	St.		ematory or other place ge's Cem	-	6/2011	Valley	Lee,	MD
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fund	01/10				22. Name and Addres	ss of Facility Bri	nsfield	Funera	al Hom	ne, P.A.
20260				nsfield, Jr		052 2	2955 Holl	<u>ywood Roa</u>	d, Leon	<u>ardtowr</u>	1, MD	20650 Approximate
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ttendi death stor: A the fi	Certificate:	2 ☐ Accident 3 ☐ Suicide	Investigate 6 Could no	t be 28e Place of In	iuny - At bo	me form c	M 1	Yes 2 ☐ No	294 Lacation /P	tract and Num	hor or Pura	I Route Number,
al or A s after 1 Direc d in by		4 ∐ Homicide	determine	building, e			ticet, lactory, office		City or Tow		Der Or Murai	THOUSE WAITES,
To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Directors After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	Medical Exa	hysician: To the best of aminer: On the basis of lurse Practioner: To the	examination	n and/or inve	estigation, in my opinio	on, death occurred a	t the time, date a	nd place, and d	due to the ca	use(s) and manner stated.
To the within To the comp	2	29b. Signature and tir		1	/	P .	29c. License	e number		29d. Date sign	ed (Month,	Day, Year)
4		30. Name and address	ss of person wh	no completed cause of	death (Item	23a) (Type,	Print)	10000	23/	11-	4-1	/
BA		Marie Taj 31. Date filed (Month,		CNRP 4168 32. Registr			ssie Drive	. Leonar	dtown, 1	MD 206	0	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36813 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mae Heckmann October 28, 2011 8:24 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Montgomery Chevy Chase <u>Brighton Gardens</u> If Under 1 Year I If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XF Days Hours Country) (Month, Day, Year) 4/22/1918 Director 487-52-3299 93 MO Usual Residence of Decedent 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery 1 X Yes 2 No Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5555 Friendship Blvd Apt. 20815 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2 X No "natural" Completed 3 Widowed 4 Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry should be filed within 72 l and Mental Hygiene. 7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Piano Teacher Private Business traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Walter Schmidt Emma Karl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Patricia Wittie / Daughter 3847 McComb ST NW Washington DC 20016 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1...
Department of I Important: If it any injury or of once. ☐ Burial 2 🗹 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) National Crematory 2011 | Falls Church, Va 21. Signature of Funeral Service Lice 22. Name and Address of Facility Joseph Gawler's Sons Inc. 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the dis a se, or complications to the sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fallur. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) <u> Acute Renal Failure</u> days Medical Due to (or as a consequence of) Examine Urosepsis davs Sequentially list conditions, if any, leading to immediate cause. Litter orderlying Cause (Disease or linjury Due to (or as a consequence of): an and requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year 2X No signed by the a 1 Yes 2X 9 Unknown P.0. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law autopsy death? nerformed^a certificate 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☑ Other (Spe 1 Tyes 2**X** No Assisted Liv ည 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Ph within 24 hours after death.

To the Funeral Director: After the 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 🔀 Natural 5 Pending Division 1 Tyes 2 🗌 No Investigation □ Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) ule D34590 10/31/2011

Registrar

State

31. Date filed (Month

Roy Fried MD 7758 Wisconsin Ave Suite 211 Bethesda, MD 20814

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 20 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month 10 :54pm Hilda D. Jones Medical 4a. Facility Name (if not institution, give street and number 4c. County of Death Examiner 4b. City, Town, or Location of Death Lake Hospice the oastal If Under 24 Hrs. 8. Date of Birth Age (In vrs. last birthday ocial Security Number 9. Birthplace (State or Foreign Funeral 1 🗆 M 2 📶 Country) Marvland Director 220-28-0876 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Princess Anne Somerset 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 26413 California Inn Road 21853 US items 2 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian event, the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ō þ 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. 3 ☑ Widowed 4 ☐ Divorced Specify: "natural", Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Dreyer Margaret Belt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13288 Pruitt Lane, Princess Anne, Md. 21853 Lois Rentschler Daughter tem 27 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of h Important: If ite cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Salisbury Crematory: 10-31-2011 4 Donation 5 Other (Specify) Salisbury, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home PA M00295 11673 Somerset Avenue, Princess Anne, Md. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. nediate Cause (Final Onset and Death Physician/ CARDIO MYOPA sease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): burial-transi Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes No Month Day Year 5 Other (specify) Pregnant at time of death 1 Yes 9 Unkno signed by the ad Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has page 2 autops To the Hospital or Attending Physician: The Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: Natural 28c. Injury at 28d. Describe how injury 5 Pending iniury work? 1 ☐ Yes 2 ☐ No death. Accident Investigation 24 hours after death Funeral Director. completed filled in by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature 0005 8410 XLA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) U State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36815 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nov • 13, Day 201 Tar 12:37 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Allegany Cumberland, MD Devlin Manor Nursing Home Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗌 F Hours Sept. Day ^{Yea} 1933 Maryland Director 220-32-4381 78 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director ms 23a or 28a-f s must be notified Allegany Cumberland 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U. S. A. 15600 Barnes Drive NE 21502 items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. ō 1 Never Married 2 Married ģ 1 ☐ Yes 2 ☐ No If Yes, Give 1953 Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White "natural", 3 XWidowed 4 ☐ Divorced Completed 1959 Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Consolidated Orchard 12 Superintendent Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edith Jane (Teeter) Jackson Harry E. Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14519 Moores Hallow Rd., Cumberland, MD 21502 Charlie A. Jackson, Jr. Son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🗌 Burial 2 🔼 Cremation 3 🗍 Removal from State Scarpelli Crematory 11/14/2011 Cumberland, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Si matur of Funeral Service Licensee 22. Name and Address of Facility Hafer Funeral Service, P.A. ohn 1302 National Hwy., LaVale, MD 23a. Par J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 6 disease or condition yeon Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or in that initiated events and burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: asn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for in the past 12 months? Month Year Day 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has autopsy performed Yes 2 within 24 hours after death.

To the Funeral Director: After this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes Certificate: To 2 HNo Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4- Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Hospital Medical Ecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) DO017565 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AJBOII mo L2U218 MD 21502 922 170 NIT

DHMH 17 Rev 7/2009

Registrar

For State Registrar

			1. Decedent's Name (F	First, Middle, L	.ast)							2. Date o		Day	Voor	3. Time of Death
	Physicia Medic		Month Day Year												12:58 A M	
	Examin	er		_		nber)									-	
-			Northwest 5. Social Security Num		tal _{Sex}	7 1 //	In ad to indicate along	Rand		s town		O Data a	f Disth	Ba		
6	Funeral Director		384-36-932	1	1 X M 2 □ F	7. Age (In yrs.		Months	Days	Hours	Min.	8. Date o	n, Day, Y	'ear)	Gount Count	place (State or Foreign try)
			Usual Residence of I		IM-1M 5 L	74	Yrs.					Aug.	27,	1937	Mich	igan
	show d at	ţō	10a. State	0b. County		10c. C	ity, Town or Lo	cation							1	0d. Inside City Limits
	Mary 28a-f otifie	rec	Maryland	Prince	George'	s Bo	wie									1X Yes 2 No
	h the	a D	10e. Street and Number			•		10f. Zip						_	of What Coun	try?
	th with ms 23 must	Funeral Director	2810 Stony	'brook				207						SA		
	r dea	by Fu	11. Marital Status1 Never Married	1 2 TX Marrie	Armod Fo	edent Ever in U proes? 2 \(\square\) No	J.S. 13.	Was Deced If Yes, spec	dent of Hi cify Cuba	ispanic Or in, Mexica	n, Puerto	Rican, etc.	No-)		Race - Americ Black, White, e	
21215-0036	1 and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at	q p	3 Widowed 4		If Yes, Gir Year or D	/e 1956 - I	1997	1 🗌 Yes	2 X No	Specify	c.			Spec	^{cify:} Whit	e
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and	ntal Her	To B	17. Father's Name (First Leslie Er									_{e (First, Mic} rrie			ame)	
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Ma	2 shouth and the shou		Jean Ann	·) Stor						-		,00e)
ē,	f Hea f Hea item other		20a. Method of Dispos	sition		20b.	Place of Disp	osition (Nar	ne of			Date Date			on - City or To	wn, State
, E	age 1 ient of nt: If ii ry or c		1 ☐ Burial 2 ☐ 4 ☐ Donation 5			n State Hi	cemetery, cre untt Cr	-		ie)	11/	1/201	1 1	va 1 do	rf, MD	
Baltimore,	permit. Page 1 Department of Important: If it any injury or o		21. Signature of Funer	ral Service Lice	ensee		2	2. Name an	d Addres		ity Rob	ert E	E		Funera	1 Home
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т			shock, or heart failure. List only one cause on each line.									Approximate Interval Between				
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<u>e</u>	an: The tifficat tor, pa		25. Was case referred	to medical					26. Pl	ace of Dea	ath (Chec	k only one)	Yes 2	No.	1 Yes	2 LJ NO
Vits	ysicia is cer direc	To Be	examiner?	No	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 🗆 D	Othe				Residen	ice 6 🛭	Other (Specify	Hospics
of	ng Ph ter thi neral	te: 1	27. Manner of Death	5 D	28a. Date		28b. Time of injury		8c. Injury	y at		28d. Desc				
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Division of Vital Records,	or Att	Certificate:	4 Homicide	determine	28e. Place build	e of Injury - At I ing, etc. (Spec	home, farm, st	reet, factor	y, office			28f. Locat City o	ion (Stre r Town,	eet and Nu. State) U	mber or Rural	Route Number,
۵	pital	cal (29a. Certifier 1.	Cartificina	hysician: To the I	e of Injury - At I	Head	Way	t the time	n data on	d place o	Son	114	Mary	land	20715
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 54 hours after death. Of the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2	Medical Exa	miner: On the ba urse Practitione	sis of examinati	ion and/or inve	stigation, in	my opinio	on, death c	occurred a	t the time, o	late and	place, and	due to the ca	use(s) and manner stated
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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month $2\overset{\scriptscriptstyle{\mathrm{Ye}}}{0}\overset{\scriptscriptstyle{\mathrm{ar}}}{1}1$ Ruth L. Lane 3:53 P M October Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b, City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Feb. 22 055-09-9762 Months Days Hours Min. Director 96 New York Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD 1 Yes 2 No Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 415 Russell Avenue #719 20877 United States 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: Completed 3X Widowed 4 □ Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance 12 Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wilma Zinckgraf Thomas W. Howe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 324 Banks Street, Fort Mill, SC 29715-2319 Robert A. Lane (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c, Location - City or Town, State Date Metropolitan Metropolitan 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) November 1, 2011 Alexandria, VA Crematory 22. Name and Address of Facility
DeVol Funeral Home, 10 East Deer Park Drive,
Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee TRACO ASTERIO M01117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final atherosclerotic coronary artery Pnysician/ disease verys disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner tension Veavs Sequentially liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pulmonan/ Completed I disease, hypothyroidism 1 ☐ Yes 2 👿 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital: မ 1 Inpatient 2 FR/Outpatient 3 IDOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred injury 5 Pending

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and proprieted filled in by the funeral director, page 2 should be detached for use as the burner man Division of Vital Records, P.O. Box 68760

2

marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical

Baltimore, Maryland 21215-0036

28c, Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one)

29d. Date signed (Month, Day, Year)

State Registrar

Medical

31. Date filed (Month, Day, Year) NOV 02 2011

Nicole Evancich, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

9901 Medical center Drive, Rockville, maryland

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amended 18 per FH FCHD KS 11/10/11 State of Maryland / Department of Health and Mental Hygiene For State Registrar 36818 201 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 10:58 PM NATHAN MILLER October MYRELL SR Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Frederick Frederick Memorial Hospital Frederick . Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs, last birthday) **Funeral** 1 **№** M 2 🗆 F Days Hours 0872571918 MD **Director** 218-03-6681 93 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov amy injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MDFrederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21702 110 Burgess Hill Way #312 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 K No Specify: 3 X Widowed 4 Divorced Specify: Completed White WWII 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+ 12 Maintenance Supervisor medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Eleanor Walker Byron H. Miller Helen M. Walker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nathan Miller, Jr. / son 4367 Old County Rd., Morrisville, NY, 13408 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 A Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/05/2011 Gaithersburg, MD Forest Oak Cemetery 22. Name and Address of Facility Stauffer Funeral Homes, P.A. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failule. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ 40 disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or iinjury Examine b Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
• Funeral Director, After this certificate has been signed by the attending physician and that initiated events resulting in death) Last burial-trai Due to (or as a consequence of): the attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 the use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death signed by the a 1 Yes 2 L 9 Unknown 9 \ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 🔲 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury 1 X Natural work?
1 Yes 2 No Accident Investigation the 6 Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier 1 🙎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29c. License number 29d. Date signed (Month, Day, Year) ar Kova 11 MOD 65443 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V) Frederick, md 400 w 7th St Iari Kova egistrar's Signature State

Registrar

DHMH 17 Rev 7/2009

2-secur

36819

			1 - State Registrar		Certificate of Death Reg. No.					
	Physici Medi		1. Decedent's Name (First, Middle	Last) Edward	Eugene	McCall	2. Date of D Month Novemb	eath	3. Time of Death 11:25a M	
9	Exami	ner	4a. Facility Name (if not institution, Hospice House o	f St.Mary's		4b. City, Town, or Lo	cation of Death	4c. County of		
	Funeral Director		5. Social Security Number 219–18–9239 Usual Residence of Decedent	6. Sex 1 X M 2 □ F	e (In yrs. last birthda 86 Yrs	Months Dave I	Hours Min. 8. Date of B	orth 9/1925 M	9. Birthplace (State or Foreign Country) (lary Land	
e, Maryla	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, retem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10a. State 10b. County Maryland St.Ma 10e. Street and Number	ry's	10c. City, Town or Ho11		-	10g. Citizen of Wha	10d. Inside City Limits 1 Yes 2 No	
	th with ns 23a must b	ineral	25225 Blue Here		and the same of th		20636		USA	
	ours after des tural", or ite al Examiner	þ	11. Marital Status 1 Never Married 2 Narri 3 Widowed 4 Divorced	If Yes, Give Year or Dates.		3. Was Decedent of Hispa If Yes, specify Cuban, N	inic Origin? (Specify Yes or No Mexican, Puerto Rican, etc.) Specify:	Black,	American Indian, White, etc. White	
	within 72 ho /giene, ner than "na t, the Medic	Completed	15. Deceden (Specify only highes Elementary/Seconday (0-12) 12	t's Education st grade completed) College (1-4 or 5	(Gir	cedent's Usual Occupation re kind of work done during DO NOT use retired) Ship Pilo	ng most of working	16b. Kind of Busin	,	
	should be filed and Mental Hy, is marked oth raumatic event.	To Be	17. Father's Name (First, Middle, La Edward	,	Call	-	. Mother's Name (First, Middle Catherine Vi	TALL THE	anks	
	d 2 shoualth and alth and 27 is mer		19a. Informant's Name/Relationshi Regina E. McCal				Number or Rural Route Number			
	6 :: 3e		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (Sp.	pecify)	20b. Place of Dis	position (Name of ematory or other place) s Catholic	Date 11/05/2011	20c. Location - Cit		
Ba	permit. Par Departmer Important any injury		21. Signature of Funeral Service Li	Lardin	en)	22. Name and Address of Mattingley	Facility 7-Gardiner Fun vick Street, L	eral Home	P.A. 20650	
	Physician/ Medical Examiner		23a. Part 1. Enter the disease, or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last	a. Due to (or as a	the death. Do not a	nter the mode of dying, si	uch as cardiac or respiratory a	rrest,	Approximate Interval Between Onset and Death	
Division of Vital Records, P.O. Box 68760	requires that the death cartificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of 1 Live Birth 2 4 Pregnant at 9 Unknown	☐ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date o Month	of delivery Day Year	
	fuires that en signed t	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown							
	ine taw ate has page 2	Completed	DM				24a. Was auto perfc 1 □ Yes	osy prior ormed? deat	e autopsy findings available r to completion of cause of th? Yes 2 \[\] No	
	or en copying or Attention of Processing Visitions: Within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	To B	25. Was case referred to medical examiner? 1 Yes 2 X No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investiga	ry Zear) 28b. Time of injury M 28b. Time of injury M 1 2 restriction of injury M 3 restriction of injury M 2 restriction o						
	urs after de ral Directo		3 Suicide 6 Could no 4 Homicide determine	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)					·	
	vithin 24 hours after deat To the Funeral Director: completed filled in by the	Med				stigation, in my opinion, de death occurred at the time	e and place, and due to the ca eath occurred at the time, date a e, date and place, and due to th	nd place, and due to the cause(s) and manne	the cause(s) and manner stated. r as stated.	
	= > 2 8		29c. License number H0055751 29d. Date signed (Month, Day, Year) 11-2-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)							
			Jennifer Schmidt				ite 205, Leona	rdtown, M	D 20650	
	State Registra	e 3	11. Date filed (Month, Day, Year)	32 Registrar'	s Signature	all				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 36820 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Delores Marie Miller Month 10 Medical 2011 5:12 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Genesis HealthCare of Waldorf Waldorf Charles 5. Social Security Number **Funeral** Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign 1 M 2 Days Hours Min. 180-22-3986 Director 85 02/14/1926 Pennsylvania Usual Residence of Decedent or 28a-f show e notified at within 72 hours after death with the Maryland 10b. County Director 10c. City. Town or Location 10d. Inside City Limits MD St Mary's 1 🗆 Yes 2 😾 No Mechanicsville 10e. Street and Number ō 10f. Zip Code ms 23a or must be 10g. Citizen of What Country? Funeral 26503 Tin Top School Road 20659 USA ıral", or items 2 I Examiner mus 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", 3 Widowed 4 X Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker 7th Homemaker 1 and 2 should be filed w f Health and Mental Hygi item 27 is marked othe Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George McKinsey Elalley Doll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
26503 Tin Top School Road Mechanicsville, MD 20659 Bernard Tyrone Miller/Son injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols 10/30/2011 Charlotte Hall, MD Sona of Funeral Service License 22. Name and Address of Facility Brinsfield-Echols Funeral Home PA tall 30195 Three Notch Road Charlotte Hall, MD 20622 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph sician disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or): or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗶 No ☐ Pregnant at time of death ☐ Unknown 5 Other (specify) Month Day Year 1 ☐ Yes 2 ☐ Unknowr the signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed 1 ☐ Yes 2 🕱 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s perform certificate Yes 2 No 1 🗌 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) Hospital: 1 Yes ျာ 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) n 24 hours after vocame. ne Funeral Director: After th funeral Certificate: 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? Investigation Accident 2 🗌 No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 70 86

who completed cause of death (Item

OCT 3

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36821 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day 28, 2011 4:35 P Satya Manocha Dctober Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 5135 Marlin Ct. Charles | Waldorf If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) India 7. Age (In yrs. last birthday) 8. Date of Birth Social Security Number 6. Sex **Funeral** Months 08/12/1925 1 🗆 M 2 💢 F **Director** 86 218-06-4649 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nortant any injury or other than" in the many injury or other than "nortant any injury or other than "nortant any injury or other than". 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Maryland Charles Waldorf 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number Funeral IISA 5135 Marlin Ct 20603 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 11. Marital Status Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 2 **X** No Yes 1 ☐ Yes 2X No Specify. Specify: Asian Indian If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lekh Raj Mehndiratta Saraswati Mehndiratta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5135 Marlin Ct., Waldorf, MD 20603 Sudhir Manocha/Son 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State 4 Donation 5 Other (Specify) Brinsfield-EcholsCrem. 10/29/2011 Charlotte Hall, MD 21. Sign ure of Funeral Service Licensee 22. Name and Address of Facility BrinsfieldEchols F.H., P.A. 50 -MO0817 30195 Three Notch Rd., Charlotte Hall, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 10 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury attending physician and I for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Records, page 2 this certificate Division of Vital After

the funeral director, To the Hospital or Attend within 24 hours after death To the Funeral Director; completed

Certificate: To

Medical

28c. Injury at work?
1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State 1 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

1 Yes 2 No

78

0

Yes

4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

26. Place of Death (Check only one)

2) RML State

Registrar

·MA 31. Date filed (Month, Day, Year,

NOV

25. Was case referred to medica

2

5 Pending

examiner?

1 Yes

1 Natural

Manner of Deatl

0 0 strar's Signature

28a. Date of injury (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

iniury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2011 36822 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2<u>8,</u> 2011 12:14 p.m October 0 Theodore Bernard Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** St. Mary's Hospice House of St. Mary's Callaway Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) 1 XM 2 □ F Min. (Month, Day, Year) 04/19/1933 Months Days Hours **Director** 579-48-0059 Washington, Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location with the Maryland Director 1 Yes 2 X No Maryland St. Mary's Lexington Park 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 20653 21895 Pegg Road United States permit. Page 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ρ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: "natural", Completed 3 Divorced 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) t of Health and Mental Hygiene. If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Logistics Technician Defense Contractor other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ <u>Margaret Bernadette Gesualdi</u> Theodore J. Muth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thunderbird Drive, Lusby, MD 20657 Timothy O/Connor/Friend 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) ☐ Burial 2 X Cremation 3 ☐ Removal from State ö Department of Important: If any injury or Brinsfield-Echols Cre 10/31/2011 | Charlotte Hall, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service I center 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Danielle Ward M01403 20650 22955 Hollywood Road, Leonardtown, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) Medical Due to (or as a conseque) ce of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) and -trans that initiated events resulting in death) Last Due to (or as a consequence of): burial-t attending physician I for use as the buria Physician/Medical The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown cate has been significant categories, page 2 should be Completed 24b. Were autopsy findings available 24a Was an autopsy performe Yes 2 prior to completion of cause of this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: Wo spice 2 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 27. Manner of Death Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Prantioner: To the best of any knowledge, de diet the time, date and place, and due to the pause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H005575

State Registrar 30. Name and address 9

31. Date filed (Month, Day, Year,

Jennifer/Schmidt, D.O.

NOV

DHMH 17 Rev 7/2009

40900 Merchants Lane, Suite 205, Leonardtown, MD

20650

erson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State 36824 Certificate of Death 3. Time of Death Decedent's Name (First Middle Last) 2. Date of Death Month Physician/ 23/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under If Under 24 Hrs. 8. Date of Birth Social Security Number **Funeral** Hours Min (Month, Day, Year) Director 1 **Z** M 2 □ F 117-34-9542 5, 1929 Dominican Republic 82 Usual Residence of Dece ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 X Yes 2 No Prince George's Bowie Maryland 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? Funeral USA 20715 4101 Chelmont Lane or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Examiner Black, White, etc. ģ 1 Never Married 2 X Married Yes 2 KNo Baltimore, Maryland 21215-0036 nan "natural", o Medical Exam If Yes, Give Year or Dates 1 X Yes 2 □ No Specify: Completed 3 Widowed 4 Divorced Dominican White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working 2 should be filed within 72 l th and Mental Hygiene. 77 is marked other than "r life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other traumatic event, the Religion Pastor Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mercedes Grullon Hipolito Mateo Department of Health and Important: If item 27 is n any injury or other traum: 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4101 Chelmont Lane Bowie, MD 20715 David Aseng/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Lakemont
emorial Gardens 1 X Burial 2 Cremation 3 Removal from State 10/29/2011 Davidsonville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Robert E. Evans Funeral Home Road Bowie, MD 20715 16000 Annapolis 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset/and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) **Examiner** ul mover Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Exami the burial-transit that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death
Unknown signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has page 2 1 Yes 2 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ည 1- Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 20c License number 29b. Signature and title of certifi who completed cause of death (Item 23a) (Type, Print) ENTA 31. Date filed (Month, Day, Year) State NOV 0 1 2011

DHMH 17 Rev 06-2011

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan	•	rtificate of E			g. No. 201	1 36825
	Physicia		1. Decedent's Name (First, Middle, Last)	HOORE				2. Date of Death Month	Day Year 30,2011	3. Time of Death
	Medic Examin		4a. Facility Name (if not institution, give str	eet and number)			Location of Death		4c. County of De	ath
	Funeral Director		217-30-0924	M 2 F 7. Age (In yrs. le		If Under 1 Year Months Days	BURNI If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, July 07		RUNDEL irthplace (State or Foreign ountry) DISTRICT Columbia
Maryland	8a-f show tifled at	Director	Usual Residence of Decedent 10a. State 10b. County DE Kent	10c. Cit Ha	y, Town or Lo arringt	cation				10d. Inside City Limits 1 ☐ Yes 2 🔀 No
with the N	is 23a or 2 nust be no	Funeral Di	10e. Street and Number 80 Doe Court			10f. Zip Code 199	52	10	og. Citizen of What C USA	Country?
)036 irs after deatl	tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 XWidowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 🖾 Yes 2 🗆 No If Yes, Give Year or Dates.	152ー!	Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 🛣 No		ecify Yes or No- Rican, etc.)	Black, Wh	nerican Indian, ite, etc. White
21215-0036 within 72 hours after	iene. r than "nat the Medica	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Seconday (0-12)		(Give life. D	dent's Usual Occup: kind of work done d O NOT use retired) ims Adjus	luring most of work	ing	16b. Kind of Busines Insuran	
<u>0</u>	nd Mental Hyg marked othe matic event,	To Be	17. Father's Name (First, Middle, Last) George E. Moore				18. Mother's Nam Ada Cl	ne (First, Middle, M naney	aiden Surname)	
e, Mary	th an 27 is trau		19a. Informant's Name/Relationship (Type Jeanette Piper / D		19b. Mailir 631	ng Address (Street & Cypress	nnd Number or Run Road Seve	al Route Number, G erna Park	City or Town, State, 2 MD 2114	Zip Code) 6
0	O == F		20a. Method of Disposition 1	amousi from State	emetery, crer	esition (Name of matory or other place ematory,	Octok	per 31,	Baltimore	
Gall	Department Important: any injury o		21. Signature of Funeral Service Licensee		B 49	2. Name and Address Arranco & 95 Ritchi	Sons, P. E Hwy,	.A. Sever Sever	na Park F na Park,	uneral Home MD 21146
	sician/ Medical xaminer	ıer	23a. Part Engler the Assease, or complic shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate	ations that caused the death cause on each line. SEPTIC Due to (or as a consequence) Due to (or as a consequence)	SHOC					Approximate Interval Between Onset and Death
68 / 60 ertificate be executed	physician and the burial-transit	edical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last d.	Due to (or as a consequ	uence of):					
BOX 5 8 death certi	been signed by the attending p should be detached for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No g □ Unknown	c. If yes, outcome of pregna 1 Live Birth 2 Feta 4 Pregnant at time of c 9 Unknown	ıl death 3 [Ectopic pregnand Other (specify)	у		23d. Date of a Month	lelivery Day Year
DIVISION OF VITAL RECORDS, F.O. To the Hospital or Attending Physician: The law requires that the	gnec be de	þ	Part II. Other significant conditions cont	ributing to death but not res	ulting in the u	underlying cause giv	en in Part I.			to the cause of death? Probably 4 Unknown
DIVISION OT VITAI KECORDS, al or Attending Physician: The law required	cate has be	Completed						24a. Was an autops perform 1 \sum Yes 2	prior to ned? death	autopsy findings available o completion of cause of cause of 2 🕱 No
VITal ysician	is c er tifii director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 🗶 No	spital:	ER/Outpatier	Othe	ace of Death (Checer: 4 Nursing H		nce 6 🗆 Other (Spi	ecify)
Off Of ending Ph	eath. or: After th he funeral	Certificate:	27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	work	vat ? Yes 2 □ No	28d. Describe hov	w injury occurred	
UIVISI	within 24 hours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2		3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify)			City or Town,	·	
he Hosp	in 24 ho he Fune pleted fi	Medical	(Check 2 Medical Examine	an: To the best of my knowler: On the basis of examination Practioner: To the best of my	and/or inves	tigation, in my opinic	n, death occurred a	at the time, date and	d place, and due to th	e cause(s) and manner stated.
Tot	To t		29b. Signature and title of certifier	Gióngrocz ME		29c. License	number		ed. Date signed (Mor	
5	5+1		30. Name and address of person who con	pleted cause of death (Item	23a) (Type, F	Print)				
	Stat Registra	e	SUILLERMO DOSE GIA 31. Date filed (Month, NOVa 0 1 20	11 32. Redistrar's Signat	ure A.	parks	ne ² erei	U BURNIS	"WD 50	16.1

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

		For State Registrar			of Maryla		partmer <i>ertificat</i>			and N	/lental Hy	Reg. No	20	11	3682
Physicia Medic Examin	cal	1. Decedent's Name (First,) Morris 4a. Facility Name (if not inst.)	L. A	1a-55	nber)		4b. City.	Town, or	Location	of Death	2. Date of Domestin	De Da	ay 11 2 c. County of	ear O//	3. Time of Death 2/ /3 PM
Funeral		University of / 5. Social Security Number 214-52-0694	Marylan 6. Sex	d med			1	301-	If Under Hours	مدو	8. Date of Bi (Month, D Jan 7	rth		J. Birthpl	ace (State or Foreign Land
Director -t show per time at the per time at	Director	Usual Residence of Decec 10a. State 10b. C	dent	X M 2 □ F	10c. (City, Town or		,			Jan /	1949			TLANO Od. Inside City Limits 1 □ Yes 2 ▼No
with the Ma is 23a or 28a nust be notif	Funeral Dire	MD Kei 10e. Street and Number 11615 Still	_	Rd.	We	<u>orton</u>	10f. Zip	678					itizen of Wh	at Count	
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at anone.	by	11. Marital Status 1 Never Married 2 3 Widowed 4 Div	Married	12. Was Dece Armed Fo 1 Yes If Yes, Giv Year or Da	2 🛣 No	J.S. 1		cify Cubar	n, Mexica	n, Puerto	ecify Yes or No Rican, etc.)	-	14. Race - Black, Specify:	White, e	
within 72 hou giene. Ier than "natier the Medica"; the Medica	Completed			ucation de co <i>mpleted)</i> College (1		(Gi life	cedent's Usu ve kind of wo DO NOT use esel Me	rk done d e retired)	uring mos	st of work	ing		Kind of Busin		
ould be filed nd Mental Hy marked oth matic event	To Be	17. Father's Name (First, Mic Ernest Leon 19a. Informant's Name/Rela	Masse			10b M	ailing Address	/Street a	Lul	a Ma	e (First, Middle e Morri	İs		a Zin O	nde)
ge 1 and 2 sh t of Health ar If item 27 is or other trau		Cheryl Mass 20a. Method of Disposition 1 😿 Burial 2 🗆 Crem	sey	(wife	20b	. Place of Dis		ill F	ond	Rd.	Wortor Date	1, MI		78	
permit. Pag Departmen Important: any injury once.		4 Donation 5 0 21. Signature of June at Se	100		M005		Hill C 22 Name ar Galen 118 W	a Fu	s of Facili	L Hon	17/11 ne of S Galen	teph	en L.	Sch	
Physician/ Medical		23a Part . Enter the disea shock, or leart failure Immediate Cause (Final disease or condition resulting in death)	ase, or compl List only on	e cause on ea	caused the de	ath. Do not e	enter the mod	e of dying	g, such as	cardiac					Approximate Interval Between Onset and Death
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be executed sician and e burial-transi	ical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	J	Due to ((or as a conse	equence of):									
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnar in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	nt 2	3c. If yes, out	come of preg Birth 2 Fe nant at time on	etal death	3 Ectopic 5 Other (sp		у				23d. Date Monti		ry Day Year
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anding Physici ath. r: After this cer ne funeral direc	Certificate: To B	2 Accident I	Pending nvestigation	28a. Date	Inpatient 2 [of injury th, Day, Year)	ER/Outpa 28b. Time injur	of 2	Othe Sec. Injury work	er: 4 \square N	ursing Ho	ome 5 Res 28d. Describe			Specify)	
pital or Atte burs after de eral Directo filled in by th		4 Homicide c	Could not be determined	buildi	of Injury - At ng, etc. (Spec	sify)					City or To	wn, State	e)		Route Number,
To the Hos within 24 ht To the Funt completely	Medical	(Check 2 ☐ Mec only one) 3 ☐ Cer 29b. Signature and title of c	dical Examin tifying Nurse ertifier	er: On the bas Practitioner	sis of examinat To the best o	ion and/or in	estigation, in ge, death occ	my opinio urred at th License	n, death o ne time, da number	ccurred a ate and pla	ace, and due to	and place the caus	e, and due to	the cau	se(s) and manner stated tated.
V		Releura E 30. Name and address of pe	erson who co	mpleted caus	e of death (Ita	em 23a) (Typ	e, Print)								1,2011
Stat Registra		Rebecca E. 31. Date filed (Month, Day,) NOV	(ear) 201	1	egistrar's Sigr	nature.	arkel	701	ATh	Green	ine st	rit	- (50-(-	7,~	ore, MD 2120
				1000	-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State		State o	f Marylan		artment of F tificate of D		and M			2011	36827
6		-	Registrar 1. Decedent's Name (Fin	rst, Middle, Last,)						2. Date of De	ath		3. Time of Death
	Physicia Medic		Marie R	. Nev	reu						October	31, 2	201 ^{Year}	12:20 am
	Examin		4a. Facility Name (if not Holy Cros			ber)		4b. City, Town, or Silver				4c. Coi Mo 1	inty of Death ntgome1	cy
(Ex	Funeral		5. Social Security Numb	er 6. Se	· 1	7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under	r 24 Hrs. Min.	8. Date of Birl (Month, Da		9. Birth	place (State or Foreign
	Director		434-26-345	1 L	□ M 2 🛂 F	91	Yrs.	Wioning	110010		April 3		LA	,
	nd how at	ង	Usual Residence of De 10a. State 10b	b. County		10c. City	y, Town or Lo	ation					1	10d. Inside City Limits
	Aaryla 8a-f tified	Director	MD	Montgom	ery		Silve	er Spring	5					1 🗆 Yes 2 🍱 No
	the Naor 2		10e. Street and Number					10f. Zip Code				10g. Citizen	of What Cour	ntry?
	h with	Funeral	2505 Glen					20906				U	SA	
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 3 ☑ Widowed 4 ☐	2 Married	 Was Dece Armed For 1 ☐ Yes If Yes, Give Year or Da 	2 🔀 No e	1	Vas Decedent of H Yes, specify Cuba	ın, Mexica	n, Puerto I			Race - Americ Black, White, Nat:	
ŏ	hours natur dical J	lete		5. Decedent's Ed	ucation		16a. Deced	ent's Usual Occup	ation	. 4 . 4		16b. Kind	of Business/In	dustry
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ar Z	nd Me s marl		19a. Informant's Name/				19b, Mailin	g Address (Street a	and Numb	er or Rura	Route Numbe	r, City or Tow	n, State, Zip (Code)
Š	d 2 st ealth a n 27 is er tra		Irwin L. N	Neveu, J	r./Son		15 S	ydney Lar	ne, S	taffo	ord, VA	22554	,	
altimore,	Page 1 an nent of He int: If iten iry or oth		20a. Method of Disposit 1 🖾 Burial 2 🗆 C 4 🗆 Donation 5	Cremation 3 🗆		State C	emetery, cren	sition (Name of natory or other plac aven Ceme			^{0ate} 4, 011		ion - City or To r Spri	
Balti	permit. Departr Importa any inju	12	21. Signature of Funeral	Service License	Aver	alo	22 F1	Name and Addres	ss of Facil	ity Lins	Funeral	L Home	Inc.	g. MD 20901
المد	hysician/ Medical		23a. Part 1. Enter the d shock, or heart fai Immediate Cause (Fina disease or condition resulting in death)	ilure. List only on	Multi	on line. -organ	h. Do not ente	r the mode of dyin	g, such as	cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
	Examiner		recently in deality		Colit	or as a consequ	uence of):							
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	requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent preg in the past 12 mont 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?	1 Live	nant at time of o	al death 3	Ectopic pregnand Other (specify)	У			23d	. Date of deliv Month	rery Day Year
P.0	s that t gned b be deta	by P	Part II. Other significan		-		-			t 1.				he cause of death?
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Division of Vital Records,	The law ate has page 2										1 \(\text{Yes}	psy prmed?	4b. Were auto prior to co death? 1 \sum Yes	psy findings available ompletion of cause of
Ita	ysician: is certific director,) Be	25. Was case referred to examiner? 1 ☐ Yes 2 耳No	l _z	lospital:	Inpatient 2 🗍	5B/0 : "	Oth	er.	ath (Check			011 (0	,
ot	this alo	te: To	27. Manner of Death		28a. Date	of injury	28b. Time of	28c. Injur	y at		me 5 🗌 Resi 28d. Describe l			//
O	endin eath. or: Aftu he fur	ficat	2 Accident	Pending Investigation		th, Day, Year)	injury	M 1 □	Yes 2	□No				
Divisi	Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificetely filled in by the funeral director,	Certificate:	3 ☐ Suicide 6 4 ☐ Homicide	Could not be determined	28e. Place	of Injury - At hong, etc. (Specify	me, farm, stre	eet, factory, office			28f. Location (S City or Tov		ımber or Rura	l Route Number,
	To the Hospital or Attending F within 24 hours after death. To the Funeral Director: After Completely filled in by the funer	Medical	(Check 2 🗌	Medical Examin	er: On the bas	is of examination	n and/or invest	occurred at the time igation, in my opinion death occurred at t	on, death o	occurred at	the time, date a	and place, and	d due to the ca	use(s) and manner stated.
	To the I	Ī	29b. Signature and title	of certifie				29c. License	e number				gned (Month,	
	4			NOW			M.D.	D641	.00			Octob	er 31,	2011
			30. Name and address of Smitha Bh	ikkaji,	MD	1500	Forest	Glen Roa	ad, S	ilveı	Sprin	g, MD	20910	
	Sta Registra		31. Date filed (Month, Da	0 2 201°	37. R	egistrar's Signat	par de	Ked.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36828 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nycum Earlston Robert Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Allegany Cumberland WHMS-RMC Birthplace (State or Foreign Country)
 MD Social Security Numbe If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 🖳 M 2 🗆 F Hours Months Sep 2. °f'929 **Director** <u>213-24-6193</u> ms 23a or 28a-f show must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Cumberland MD Allegany 1 X Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21502 730 Furnace Street or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, other than "natural", or iter rent, the Medical Examiner Armed Forces? Black, White, etc. 1 XNever Married 2 Married ò 1 Yes 2 No Specify: Baltimore, Maryland 21215-0036 white 1951-195# Completed 3 Widowed 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Fairchild Industries Electrical Engineer 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be file and Mental H Amanda Trail ဂ Lloyd E. Nycum of Health and Mei titem 27 is mark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
184 Celestrial Terrace Greencastle 19a. Informant's Name/Relationship (Type, Print) 184 Celestrial Terrace David Nycum son 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of permit. Page 1
Department of I
Important: If it
any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 11/9/201 MD Sunset Memorial Park Cumberland 21. Agnature of Funeral Service Lie 22. Name an Scarbein Fullieral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ 12 ORONARY Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate Examine Due to or as a consequence of cause, Enter Underlying burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 as the IF FEMALE: signed by the attendin d be detached for use 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown no the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should is 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🖪 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medica Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at work? Certificate: 27. Manner of Death 28a. Date of injury 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 \square Pending 1 🗌 Yes 2 🗀 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the I within 2 only one 29d. Date signed (Month, Day, Year) 29b. Signatu TH 30. Name and address of person who completed cause of death (Item 23a) 🕏 pe, Print) 200 Glenn St. Ste. 302 Cumberland, MD

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Poor-1 233 4 M Kevin Wras 10 201 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death St. Mary's Hospice House of St. Mary's Callaway 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Age (In yrs. last birthday, 8. Date of Birth 1 X M 2 🗆 F Months Hours **Director** 09/29/1964 532-74-3362 Kansas Usual Residence of Decedent 28a-f show 10b. County with the Maryland 10c. City. Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Yes 2 No Maryland St. Mary's California 23a or 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23210 Piney Wood 20619 United States items Page 1 and 2 should be filed within 72 hours after death \u00fanter Health and Mental Hygiene.
sent. If Health and Mental Hygiene.
sent. If Hem 27 is marked other than "natural", or items
ury or other traumatic event, the Medical Examiner mu 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 X Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tyes 2 X No Specify. 3 Widowed 4 Divorced Specify Completed White and Mental Hygiene.

is marked other than "natural aumatic event, the Medical." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Procurement Contractor U.S. Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Larry Wray Poort Linda Suzanne Finch 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Linda S. Barnes/Mother 5291 Springfield Road, Williston, SC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1.
Department of I Important: If it any injury or or once. 1 🗌 Burial 2 🛣 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Brinsfield-Echols Cre 11/02/2011 Charlotte Hall, MD Signatura of Funeral School 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Brinsfield, 22955 Hollywood Road, Leonardtown, MD M000521 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ myxopapillan disease or condition Medical resulting in death) Due to (* as a con sequence of): Examiner Esquerniany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attending physician and Exami signed by the attending physician and be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death in the past 12 months? 3 Ectopic pregnancy 5 Other (specify) Month Pregnant at time of death Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been sig page 2 should b 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗌 Yes 2 🗌 No filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 2 No ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier

State

Registrar

30. Name and address

Jennifer

Schmidt,

40900 Merchants Lane, Suite 205, Leonardtown,

person who completed cause of death (Item 23a) (Type, Print)

trar's Signature

D.O.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 36830 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2011 Carolyn Burford Polsin October 6:15 p.m^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** St. Mary's 24602 Blackistone Road Hollywood 8. Date of Birth (Month, Day, Year) 04/09/1946 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 💢 Months Days Utah Director 505-56-0105 Usual Residence of Decedent 28a-f show 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits Director 1 Yes 2 XNo Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20636 United States 24602 Blackistone Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give 3 Widowed 4 Divorced Completed Year or Dates. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 In and Mental Hygiene.
7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) $\frac{2}{2}$ Nursing Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic Alvin Felix Meyer Vivian Buford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 24602 Blackistone Road, Hollywood, MD Michael J. Polsin/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🛛 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 11/01/2011 Ridge, Maryland St. Michael's Cem 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Danielle Ward M01403 2955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examin and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) physician a s the burial-t Physician/Medical Division of Vital Records, P.O. Box 68760 s been signed by the attending p should be detached for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performet? 1 Yes 2 No prior to completion of cause of death? this certificate has page 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 1 Residence 6 Other (Specify) 1 Tyes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated re and title of certifie 29b. Signat 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 5 RML 25365 Point Lookout Road, Leonardtown, MD II M.D. William D. Boyd, 31. Date filed (Month, Day, Year) egistrar's Signatu State 1 2011 NOV Registrar

Amend #1 . Health			AT WI loads Type of			ndelible Inlartment of H				Legible.	
		•	For State Registrar	, mary lari		rtificate of D			Reg. No.	201	1 3683
	Physicia	n/	1. Decedent's Name (First, Middle, Last)					2. Date of Dea		n o alYear	3. Time of Death
and the same of th	Medic	al	Carol Elizabeth Prol			I 11 07 T	. I ! D !!	Octobe:			3:15 Pm
	Examin	er	4a. Facility Name (if not institution, give street and num Anne Arundel Medical Ce	enter		Annapo1		T	Anr	County of Death	lel
	Funeral Director		5. Social Security Number 190–28–0883 Usual Residence of Decedent	7. Age (In yrs. Ia 77	Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day 6/29/19	y, Year)	Cou	nplace (State or Foreign ntry) nnsylvania
Maryland	8a-f show tified at	rector	10a. State 10b. County Maryland Anne Arundel	10c. City	, Town or Lo		apolis				10d. Inside City Limits 1 Yes 2 □ No
with the N	s 23a or 2 ust be no	eral Di	10e. Street and Number 611 Admiral Drive #103			10f. Zip Code	21403		10g. Citiz	zen of What Co	untry? USA
036 rs after death	n and Mental Hygiene. P is marked other than "natural", or items 23a or 28a-f sho raumatic event, the Medical Examinar must be notified at	Completed by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced 12. Was Dece Armed For 1 □ Yes If Yes, Givi	9		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 🙀 No		ecify Yes or No- Rican, etc.)		14. Race - Amer Black, White Specify:	
Baltimore, Maryland 21215-0036	ne. han "natu e Medical	omplet	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-	4 or 5+)	(Give life. D	dent's Usual Occup kind of work done o O NOT use retired)	during most of work	ing		nd of Business/I	ndustry
d 21	Hygien other t	Be C	12 17. Father's Name (First, Middle, Last)		Bus	siness Mar	nager 18. Mother's Nam	e (First, Middle,		Retail	
r lan o dbe filk	nrked c	입	Eugene Warner					y Ester		,	
, Mary d 2 should	alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (Type, Print) Missy Muhly - Daughter		19b. Maili 508	ng Address (Street a Nightinga	and Number or Run ale Court	al Route Numbe , Mille	r, City or] rsvi	Town, State, Zip 11e, MD	^{Code)} 21108
more, Page 1 an	Department of Health and Menta Important: If item 27 is marked any injury or other traumatic esone.		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from 4 Donation 5 Other (Specify)	C4-4- C6	_{emetery, cre} . Vetera	osition (Name of matory or other place ans Cemete	ery 10/3	Date 1/11	Crov	cation - City or wnsvill	e, MD
Balti permit.	Departn Importa any inju once.		21. Signature of Funeral Service Licensee Mugelin 1. Woher	7	2	2. Name and Addres	ss of Facility JO	hn M. T	ayloı , Anı	r Funera napolis	al Home , MD 21401
p ► Ph	ysician/	(i. 1	23a. Part 1. Enter the disease, or complications that c shock, or heart failure. List only one cause in en Immediate Cause (Final disease or condition		n. Do not ent	11	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Medical xaminer	10	Sequentially list conditions.	or as a consequ							
executed	ind transit	Examiner	Cause (Disease or injury that initiated events c.	or as a consequ							
	ohysician a the burial-	I— I	resulting in death) Last Due to (or as a consequ	ence oi).						
Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death cartificate be	the attending physician and shed for use as the burial-transit	Physician/Medica	in the past 12 months?	come of pregnal Birth 2 Feta nant at time of d own	Ideath 3	☐ Ectopic pregnanc☐ Other (specify) _	ey .		2	23d. Date of del Month	ivery Day Year
s, P.O.	signed by the a d be detached f	Š	Part II. Other significant conditions contributing to de	eath but not resi	ulting in the	underlying cause giv	ven in Part I.	~	-		the cause of death?
ecord:	has been się ge 2 should b	Completed						24a. Was auto		prior to death?	opsy findings available completion of cause of
~	certificate has bilirector, page 2 s		25. Was case referred to medical			26. PI	ace of Death (Chec	1 Yes	200	1 Yes	2 🗆 No
Vita Nysicia	this certific ral director,	To Be	examiner? 1 Yes 2 No Hospital:	Inpatient 2 🗌	ER/Outpatie	Oth	or:	ome 5 Resid	dence 6	Other (Spec	ify)
on of	ith. ; After thi e funeral		27. Manner of Death 1 Natural 5 Pending (Mont) 2 Accident Investigation	of injury h, Day, Year)	28b. Time o injury	work	y at ⟨? Yes 2 □ No	28d. Describe h	now injury	occurred	
Division of Vital Records,	ours after death. eral Director; A filled in by the f	Certificate:	3 Suicide 6 Could not be 28e. Place	of Injury - At ho		reet, factory, office		28f. Location (S City or Tov		l Number or Rui	ral Route Number,
Hospit	within 24 hours a To the Funeral C	Medical	29a. Certifier (Check only one) Certifying Physician: To the base of the control	is of examination	and/or inves	stigation, in my opinio	on, death occurred a	it the time, date a	and place,	and due to the	cause(s) and manner stated.
10 P	Voith con a		29b. Signature and title of certifier	m,)	29c. License	72190		29d. Date	e signed (Month) $\frac{76}{76}$, Day, Year)
	5w			e of death (Item Medical	23a) (Type, Park		polis, Ma	ryland	2140	01	
	Star Registra		31. Date filed (Month, Day, Year) 1 33. R	egistrar's Signat	. ba	uks					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36832 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year 201 Mopth Physician/ 1130 am Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Anne Arundel Medical Center Annapolis 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** 90 Hours (Month, Day, Year) 577-12-3327 1 **Z**M 2 □ F Director Maryland Oct. 29,1920 Yrs or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location at death with the Maryland Director be notified Arnold MD Anne Arundel 1 Yes 2X No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 23a Funeral 21012 USA 510 Bay Hills Drive Examiner must items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 NoWW II

If Yes, Give
Year or Dates. Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. or i þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 🔀 No Specify: White Specify: and Mental Hygiene. 3 X Widowed 4 Divorced Completed Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I U.S. Treasury Special Agent 4 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Emma Sheppard Ernest Parker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 510 Bay Hills Drive Arnold, MD 21012 Thomas Ditto / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State October 28, cemetery, crematory or other place) 1
Burial 2
Cremation 3
Removal from State Baltimore, MD Metro Crematory, INC. 2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Sanature of Emeral Service Liv 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Ritchie Hwy, Severna Park. 28a art 1. Inter the disease, or co shock, or heart failure. List only Approximate Interval Between polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. mmediat Cause (Final disease r condition osuffing in death) nelpnd (ath STAGE Physician/ Medical Due to (or as a consequence of) Examiner Sequentially list conditions Due to (cros a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of) resulting in death) Last physician a Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE: nse 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) for in the past 12 months? Year Month Day Pregnant at time of death 2 No Unknown 9 Unknown n signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? 2 No 1 Yes filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospita Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျပ 1 Yes Impatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of/certifier 29c. License number

State Registrar

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DEFENSE Hwy A

ompleted ause of death (Item 23a) (Type, Print)

Registrar's Signature

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31. Date filed (Mo

y, Year) 0 1 NOVA POLIS MD 21401

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36833 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 972-M 10 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Center Annapolis Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign
Country) 8. Date of Birth **Funeral** Days 215-07-2206 98 **Director** 1 🗆 M 2 🔀 F Oct. 07,1913 Maryland Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Annapolis Anne Arundel MD 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21409 USA 2040 Chesapeake Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates. 2 **X**No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. Specify: Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 73 ment of Health and Mental Hygiene. ant: If item 27 is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Secretary Banking 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Louise Ritterbusch Henry Ritter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 388 Kings College Drive Arnold, MD 21012 Department of Health a Important: If item 27 is any injury or other trains Lois Gareis / Daughter injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State St. cernstary cremental to the Episcopal Nov. Church Cemetery 20 1 XBurial 2 Cremation 3 Removal from State 04 Annapolis, MD 4 ☐ Donation 5 ☐ Other (Specify) 2011 Signature of Funeral Service Licensee Barranco & Sons, P.A. Severna Park Funeral Home Severna Park, MD 21146 495 Ritchie Hwy, 23a. Part I. Enter the dise se, or complications that caused the death. Do not enter the mode of dying, shock, or h. If fillure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or injury that initiated events and I-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Pregnant at time of death ed by the a detached f 2 No 9 Unknown Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 2 No 3 Probably 4 Unknown Completed 1 Yes Were autopsy findings available prior to completion of cause of 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? of Vital Be 26. Place of Death (Check only one) Hospital Other: 2 မှ 1 Yes 1 Inpatient 2 I ER/Outpatient 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Natural injury 5 Pending Division ours after death. eral Director: Aft filled in by the fur Investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nyrse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check within 2 29d, Date signed (Month, Day, Year)

State Registrar 30. Name and address of

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DHMH 17 Rev 06-2011

person who completed cause of death (Item 23a) (Type, Print)

istrar's Signature

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	-	For State	Pleas	se Type or State o		d / Depa	artment of I	Health and					20021
=		Registrar 1. Decedent's Name	e (First, Middle, L	ast)		Cer	tificate of l	Death	2. Date of Dea	Reg. No.	201		3683L
vsician Medica		Davidica							Octobe		, 20ÎÎ		10:26P M
amine		4a. Facility Name (if Rockv111			nber)		4b. City, Town, o	r Location of Deat	h		County of De		
eral		5. Social Security Nu	umber 6	. Sex	7. Age (In yrs. Ia	ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		h	9. E		e (State or Foreign
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unst be	Funeral	13608 Da	arnestov	vn Road			20878	3		US			
amir	<u>ا</u> ۾	11. Marital Status 1 ☐ Never Marri 3 ☒ Widowed		Armed For	2 X No	li li	Vas Decedent of H f Yes, specify Cuba	an, Mexican, Puerl	pecify Yes or No- o Rican, etc.)		4. Race - Ar Black, Wh Specify: Wh	-144-	ndian,
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jury or oth		4 Donation	☐ Cremation 3 5 ☐ Other (Spe		State Co	emetery, cren e of He	sition (Name of natory or other plac aven Ceme	etery	Date DV. 5, 2011	Silv	er Sp	ring	, MD
any in		21. Signature of Fur	neral Service Lice	n. Arc	rab	5°	Name and Addre Sancis J Unive	ss of Facility Collins rsity Bly	Funera	Hen 11ver	e Inc	ng,M	D 20901
ian/		Immediate Cause (I disease or conditio	t failure. List onl Final	y one cause on ea	ch line.	n. Do not ente		ng, such as cardiad			-	Ap	pproximate erval Between nset and Death
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should be detached for use as the burial trapsit	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 ☐ Yes 2 ₹ 9 ☐ Unknown		1 Live	nant at time of d	death 3	Ectopic pregnand Other (specify)	су		2	3d. Date of Month	delivery Da	y Year
ould be deta	۵	Part II. Other signif	icant conditions	s contributing to d	eath but not res	ulting in the u	nderlying cause gi	ven in Part I.					ause of death?
C)	Completed								24a. Was autop perfo 1 Yes	osy rmed?	prior t death	to compl	findings available etion of cause of
irector) Be	25. Was case referred examiner? 1 ☐ Yes 2 ♣		Hospital:			Oth	lace of Death (Che					
ne funeral o	Certificate: To	27. Manner of Death 1 Natural 2 Accident	5 Pending Investigat	28a. Date (Mont	Inpatient 2 of injury th, Day, Year)	28b. Time of injury	28c. Injur	y at	Home 5 Resid			ecify)	
		3 ☐ Suicide 4 ☐ Homicide	6 Could no determine	ed 28e. Place buildir	ng, etc. (Specify,)	eet, factory, office		28f. Location (S City or Tow	n, State)			ute Number,
empletely fi	Medical	(Check 2	☐ Medical Exa ☐ Certifying N	hysician: To the bastiminer: On the basturse Practitioner	sis of examination	and/or invest	igation, in my opini death occurred at	on, death occurred the time, date and	at the time, date a	nd place, he cause(s	and due to the s) and manne	ne cause(er as state	
6		255. Signature and I	late of certifier	11. (MALLA		29c. Licens				signed (Mo		

Registrar

DHMH 17 Rev 06-2011

State

Registrar's Signature

50 W. Edmonston Drive, #207, Rockville, MD 20852

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas V. Joseph, MD

31. Date filed (Month, Day, Year) NOV 02 2011

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	•	For State Registrar			naryian		tificate of	Health and Death		Reg. N	201	1 36835
Physicia		1. Decedent's Name Edward Y		.ast)					2. Date of De		ay 2011	3. Time of Death 5:00 A M
Medic Examin		4a. Facility Name (if	not institution, g	ive street and number)				or Location of Deat			c. County of Dea	
Funeral		9863 01d 5. Social Security Nu	-		ge (In vrs. la	ast birthday)	Ellico If Under 1 Year	tt City If Under 24 Hrs	8. Date of Bi		Howard	thplace (State or Foreign
Director		577-76-98 Usual Residence of	809	1 🖾 M 2 🗆 F		96 ^{Yrs.}	Months Days	Hours Min			15 6	nina nina
faryland 8a-f show tified at	ector	10a. State Maryland	10b. County Montgo	mery		ver Sp						10d. Inside City Limits 1 ☐ Yes 2 🛣 No
with the N s 23a or 2 ust be no	Funeral Director	10e. Street and Num 2001 Aven		Way			10f. Zip Code 2090	4		-	itizen of What Co	•
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of health and Mental Hygiene. Department of health and Mental Hygiene. Department of health and Mental Hygiene. And Constraint if time Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ह	11. Marital Status 1 Never Marri 3 Widowed		12. Was Decedent Armed Forces 1 Yes 2 If Yes, Give Year or Dates.	?		Vas Decedent of H f Yes, specify Cub	Hispanic Origin? (S an, Mexican, Puer o Specify:	pecify Yes or No- to Rican, etc.)		14. Race - Ame Black, Whit	
nin 72 houn ne. than "natu e Medical	Completed	(Spec		s Education grade completed) College (1-4 or	5+)	(Give i	lent's Usual Occup kind of work done O NOT use retired,	during most of wo	rking		Kind of Business	,
ed witl Hygier other t	a)	17. Father's Name (F	First, Middle, Las	<u> </u>		0	wner	18 Mother's Na	me (First, Middle		-	pply Store
id be fil Mental arked atic ev	ပ	Pang Hoi						Yip		, marcen	- Garriarrie)	
nd 2 shou ealth and m 27 is m her traum		19a. Informant's Na Ephraim T	. Pang	(Type, Print) (Son)				and Number or Ro Lane, Ro				
Page 1 a ment of H tant: If ite jury or oth				☐ Removal from State	e c	lace of Dispo emetery crem Park norial	sition (Name of Patory or other pla Park	Nov 5,	Date Vember 2011		ckville,	Town, State Maryland
permit Depart Impor any in		21. Signature of Fur	neral Service Lig		0689)			ess of Facility D			-	MD 20877
		23a. Part 1. Enter 1	he disease, or co	omplications that cause on each li	ed the death						raburg,	Approximate Interval Between
Physician/ Medical		Immediate Cause (I disease or condition resulting in death)		a Due to (or a	Ischo s a consequ	ence of):	Cardin	myspathy			· · · · · · · · · · · · · · · · · · ·	Onset and Death
Examiner	iner	Sequentially list con if any, leading to im cause. Enter Under	mediate	b. Due to (or a	s a consequ	ence of):						
sician and	Examiner	Cause (Disease or i that initiated events resulting in death) L	iinjury	c. Due to (or a	s a consequ	ence of):		<u></u>				
cate be e physicia s the buri	edical			d								
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial tegrit	Completed by Physician/Medi	IF FEMALE: 23b. Was decedent in the past 12 n 1 ☐ Yes 2 ☐ 9 ☐ Unknown	nonths?	23c. If yes, outcom 1 Live Birth 4 Pregnant 9 Unknown	2 Feta at time of c	I death 3	Ectopic pregnan Other (specify)	icy			23d. Date of de Month	elivery Day Year
es that the signed by be deta	by P		icant conditions	contributing to death	but not res	ulting in the u	nderlying cause gi	iven in Part I.			,	o the cause of death?
v requir s been s should	oletec	PII	CIT INC	s Ve	70116	•			24a. Was			Probably 4 Unknown utopsy findings available
Physician: The lav r this certificate has aral director, page 2	Com									opsy ormed? 2 2 N	death?	completion of cause of
sician; certific irector,) Be	25. Was case referred examiner? 1 Yes 2	ed to medical	Hospital:			_ Oth	Place of Death (Che	eck only one)			Daughter's cify)Residence
ng Phy fter this ineral d	ite: To	27. Manner of Death		1 ☐ Inpa 28a. Date of in (Month, D	jury	ER/Outpatier 28b. Time of injury	at 3 □ DOA 28c. Injui wor	ry at	Home 5 ☐ Res 28d. Describe	idence how inju	6 X Other (Sperify occurred	cify) Residence
or Attendi ifter death. Director: A in by the fu	Certificate:	2 Accident 3 Suicide 4 Homicide	Investiga 6 Could no determine	t be 28e. Place of Ir	njury - At ho	me, farm, stre		Yes 2 No	28f. Location (ıral Route Number,
Hospital 24 hours a Funeral C eted filled	Medical ((Check 2	Medical Exa	hysician: To the best of iminer: On the basis of	examination	and/or invest	igation, in my opini	ion, death occurred	at the time, date	and plac	e, and due to the	cause(s) and manner stated
4.5	Σ	only one) 3 29b. Signature and t		urse Practioner: To th	e best of my	r Knowledge, o	29c. Licens			29d. Da	ate signed (Monta) $\frac{1}{2}$	th, Day, Year)
/0				o completed cause of an, M.D., 6			rint)					
Stat Registra	-	31. Date filed (Month		32 Regis					,		,	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Agnello Pollio 30, 7:45A. Frank October | 20**1**°1 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Charlotte Hall Examiner** St. Mary's Charlotte Hall Veterans Home If Under 1 Year If Under 24 Hrs. '. Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 152-18-4790 1 X M 2 □ F Days Hours 83 NOV 124 1927 New Jersey **Director** Yrs Usual Residence of Decedent show or 28a-f shown notified at 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Calvert Maryland Owings 1 ☐ Yes 2 🕅 No 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? ortant: If item 27 is marked other than "natural", or items 23a o injury or other traumatic event, the Medical Examiner must be Funeral 1820 Candlelight Court 20736 United States 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces? 1 Å Yes 2 ☐ No If Yes, Give Year or Dates 1951-1953 Black, White, etc Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. White 3 X Widowed 4 □ Divorced Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than College (1-4 of 5+4 Elementary/Seconday (0-12) Pharmacist Pharmacy Be 18. Mother's Name (First, Middle, Maiden Surname) Maddalena Paturzo 17. Father's Name (First, Middle, Last) ပ Francesco Pollio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth T. Maresca -sister f Health 1820 Candlelight Court Owings, Maryland 20736 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State Metropolitan Crematory 11/1/2011 Alexandria, Virginia 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses Donald V. Borgwardt Funeral Home, 4400 Powder Mill Road Beltsville, Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on a chain. Approximate Interval Betw Immediate Cause (Final Physician/ nset and Death 1280 WMOYNA disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-transi Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Year 5 Other (specify) i signed by the ail Pregnant at time of death Yes 2 No Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown should peen Were autopsy findings available prior to completion of cause of 24a. Was an 24b. After this certificate has funeral director, page 2: autopsy Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: ည 1 🗌 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 🗌 Yes 2 Accident 2 No 24 hours after death e Funeral Director; Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 2. Centrying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 4+1 MD who complete cause of death (Item 23a) (Type, Print)

Ferty, M.D. 29449 Charlotte Hall Road Charlotte Hall, Maryland 20622 30. Name and address of Stephen P. Cafferty,

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

NOV 02 2011

32. Registrar's Signatu

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 26 per verb 9921 11-17-11 verb 11-17-11 verb 26 per verb 9921 11-17-11 verb 26 per verb 26 per ment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 12:29 P M November 12, 2011 Physician/ Pulkkinen Kathvleen Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Mt. Airy Kline Hospice House 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day Yea Aug • 10, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 007-18-0627 Hours 1922 Maine 1 □ M 2 💢 F 89 **Director** 10d. Inside City Limits 28a-f show 10c. City, Town or Location aţ 10a. State **Funeral Director** ian "natural", or items 23a or 28a-f s Medical Examiner must be notified 1 X Yes 2 □ No Frederick Frederick MD 10a. Citizen of What Country? Of. Zip Code 10e. Street and Number United States 1421 Taney Avenue Apt. 304 21702 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 No Specify: White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Department of Health and Mental Hygiers Important: If item 27 is marked other than any injury or other traumatic event, the Menone. Elementary/Secondary (0-12) College (1-4 or 5+) Retail Cashier Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ٩ Elsie May Richmond Amos Turney White 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7903 Hawthorne Drive, Frederick, Maryland 21702 19a. Informant's Name/Relationship (Type, Print) Sharon Phelps (Daughter) 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Livermore Falls, ME Pleasant View Cem. 11/18/2011 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Adresoff Basford P.A. Funeral Church St., Frederick, Home Maryland 21701 MO1612 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed Polymeral and as the burial-tran Due to (or as a consequence)of resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy signed by the atter in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed?

Yes 2 No 1 Yes 2 No To Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Tother (Specify) hospice 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide determined 24 hours a Funeral I Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗌 29b. Signature and title of certifier 29c. License numbe 00322 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36838 State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ John Alexander Russell October [□]3⁄0 8:16 2011 Ам Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death Annapolis **Examiner** 4c. County of Death Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Sept. | 10, 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 579-38-4901 1931 80 Washington, DC **Director** 1 🛛 M 2 🗌 F 28a-f show perinit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2X No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 21401 1020 Mastline Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No
If Yes, Give 1951— 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ð 1 Never Married 2 K Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White If Yes, Give Year or Dates. 1951-54 Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Project Manager 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Defense Contractor Be 17. Father's Name (First, Middle, Last)
Samuel George Russell 18. Mother's Name (First, Middle, Maiden Surname)
Myrtle Sadie Martin 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1509 Bromfield Way, Annapolis, MD 21409 John A. Russell, Jr./son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Baltimore Crematory Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 11/2/2011 Baltimore, Maryland 4 Donation 2.21. Signature of Juneral Service Licenses 22. Name and Address of Facility John M. Taylor Funeral Home 147 Duke of Gloucester St., Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Martle disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a l for use as the burial-Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Vear Pregnant at time of death ed by the a detached f P.O. To the Hospital or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, Tubular 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 1110 Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: မှ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death hours after death.
uneral Director: After the 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be within 24 hours area

To the Funeral Direct 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🔲 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b, Signature and title of certifier 0-30-11 Ioxl

Registrar DHMH 17 Rev 06-2011

State

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600101

2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Fo.AMEND#26 per PHY State of Maryla State 11/1/2011 AACO HEALIH DEPT. CMH Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Ines Ray 2011 4:47 A M October Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel 132 Park Road Pasadena Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth
(Month, Day, Year)
Dec. 04, 1929 9. Birthplace (State or Foreign Age (In yrs. last birthday) Funeral 1 □ M 2 🛛 F Months Davs Hours Min West Virginia 81 234-44-0807 Director Usual Residence of Decedent 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland Examiner must be notified at Director MD Anne Arundel Pasadena 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral USA 21122 132 Park Road items 2 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces?
1 ☐ Yes 2 🗶 No Black, White, etc 9 þ 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify If Yes, Give Specify "natural", Completed 3 X Widowed 4 □ Divorced Year or Dates. traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည permit. Page 1 and 2 should be Department of Health and Mentalmortant: If item 27 is marked Rosada Duffy Robert Coombs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
132 Park Road Pasadena, MD 21122 19a. Informant's Name/Relationship (Type, Print) Sharon Jernigan / Daughter injury or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date November 05 2011 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Menorial Park Glen Burnie, MD Signature of Funeral Service Licensee Barranco & Sons P.A. Severna Park Funeral Home Severna Park, MD 21146 any. 495 Ritchie Highway 23a. P. En r the disease, or complica ions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ck, or heart failure. List only ediate Cause (Final Pnysician/ disease or condition resulting in of ath) Medical Due to (or as a onse uence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Law Inversal Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregn 3 Ectopic pregnancy in the past 12 mon Month Other (specify) Pregnant at time of death q Unknown Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an After this certificate has funeral director, page 2 autopsy performed? death? Yes 2 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 28a. Date of injury (Month, Day, Year) 27. Manne 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: Natural work? 5 Pending 2 🗌 No Investigation Accident Suicide 3 Suicide 4 Homicide within 24 hours after dex To the Funeral Director completed filled in by th Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifie Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatu 29d. Date signed (Month Day, 0 200 id address of person who completed cause of deat

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State

Registrar

Year

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gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Edwin 0scar Swann 9:38 A Medical November 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall Mary's 7. Age (In yrs. last birthdav) Birthplace (State or Foreign Country) **Funeral** 8. Date of Birth sex 1 X M 2 □ F (Month, Day, Year) 07/18/1920 **Director** 213-18-3659 Washington, D.C Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. 28a-f show 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** 1 Yes 2 X No Maryland Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17400 Teagues Point Road 20637 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 X Widowed 4 ☐ Divorced Specify: White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Addictions Counselor Health Services Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Smiley Caywood Swann <u>Gertrude Irene Trotter</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peter Swann/Son 17400 Teagues Point Rd., Hughesville, MD 20637 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Donation 5 Other (Specify) Huntt Family Cemetery 11/8/2011 Waldorf, Maryland 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. 21. Sign at vision of Funeral Service Licenses M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enterthe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): g physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 for use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) Year signed by the a d be detached f 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 2 No 3 Probably 4 Unknown 1 Yes certificate has been si rector, page 2 should 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ 100 the funeral director, 26. Place of Death (C ck only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA ursing Home 5 Residence 6 Other (Specify) After this 27. Manner Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Unatural (Month, Day, Year) 5 Pending after death. Director; Af M 1 Yes Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) pleted filled in by determined within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 10 30. Name and address of person who completed cau of death (Item 23a) (Type, Print BA 1ar

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State

Registrar

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 10 onth 2011 7:00 A M Richard C. Smith Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Annapolis Genesis Spa Creek Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 F 8 15 1930 Washington, DC Director 81 579-36-0766 or 28a-f show 10a. State be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2 X No MD Anne Arundel Annapolis 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral USA 21401 2531 Sandy Run Ct. 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. "natural", or 1 Never Married 2 X Married Completed by 1 X Yes If Yes, Give 2 No 1951 Maryland 21215-0036 1 Yes 2 X No Specify: White 3 🗆 Widowed 4 🗆 Divorced 1953 Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Management Safeway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Ethel E. White Henry P. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Frances Smith / Wife 2531 Sandy Run Ct., Annapolis, MD 21401 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date or 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, injury o 4 Donation 5 Other (Specify) 11/1/2011 Kalas Crematory Edgewater, MD Ineral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) insequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a co resulting in death) Last equence of Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) Day Year 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖼 nknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perforn Yes 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: 2 **2** No Other: 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of q 29d. Date signed (Month, Dav. Year) 2011 D53/11 Hung T. Davis Name and addre ss of person who completed cause of death (Item 23a) (Type, Print)

Registrar
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State

31. Date filed (Month, Day, Year)

NOV 01

COLONY

32. Registrar's Signature

ANNAPOLIS

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State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 29 ay 201 Year Anne Sharkey 5:45 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Collingswood Nursing & Rehab. Rockville Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 082-05-0493 **Director** 1 M 2 A 94 July 17, 1917 NJ Usual Residence of Deced 28a-f show 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 X No MD Montgomery Gaithersburg 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 6429 Valley Stream Way 20882 USA items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Examiner 20 þ 1 Never Married 2 Married 1 ☐ Yes If Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify SpecifyWhite "natural", 3 X Widowed 4 Divorced Completed Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) traumatic event, the 12 <u>Bookkeeper</u> Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၀ marked David W. Dillon Lillian B. Cox 1 and 2 should b of Health and Mei item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathleen P. McManus/Daughter 6429 Stream Valley Way, Gaithersburg, MD 20882 injury or other Date 3, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important: If it any injury or of once, cemetery, crematory or other place) Nov. 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Gertrude's Cemetery 2011 Colonia, NJ Signature of Funeral Service Licensee P22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W. Silver Spring MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Advanced Dementia disease or condition Medical resulting in death) Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) burializace death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical P.O. Box 68760 use as the attending IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death 5 Other (specify) Month Day Year ed by the a detached 1 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performed? Yes 2 X death? this certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? ဂ္ 1 Yes 2 X No Other: To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 4 🖺 Nursing Home 5 🗆 Residence 6 🗆 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DDA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🖺 Natural 2 🔲 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of Pertific 29c. License number 29d. Date signed (Month. Day, Year) D30132 October 31, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M. Rita Ghosh, MD 14812 Physicians Lane, Rockville, MD 20850 31. Date filed (Month, Day, Year) 32 Registrar's Signature State NOV 02 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 24a & 26 per verbal G921 11/1 All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 36843 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Annette Lynn Short October 2011 3:30 P M Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 20452 Watkins Meadow Dr. Germantown Montgomery Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🗶 F Months Days Hours Director 230-84-7736 December 20, 1953 57 Country) Virginia Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. Count 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Germantown 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 20452 Watkins Meadow Dr. 20876 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black. White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) National Geographic Elementary/Seconday (0-12) College (1-4 or 5+) Treasury Specialist Society Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Steve Soroka Lilian Edge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Randall Short / Husband 20452 Watkins Meadow Dr. Germantown, MD 20876 Injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) November 10 Polk Memorial Gardens Columbus, North Carolina 2011 21. Signature of Funeral Service Licensee any in 22. Name and Address of Facility 5755 Castlewellan Dr. Alexandria, VA 22315 Karnhan Jefferson Funeral Chapel Pal 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Squamous Onset and Death Physician/ Cell Cancer of oral Cavily disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year detached g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Division of Vital Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy after death.

Director: After this certificate I performed' death? 2 🗌 No Yes 2 No Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 No Hospital 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work Accident Investigation 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nuce Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the Within 2 only one) 29b. Signature and title of centific 29d. Date signed (Month, Day, Year) 20066346 MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAN741 1650 ORLEANS STREET /ROOM G92, BALTIMORE MD 2/231-100 MAKUS 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1720 Registrar

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36844 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Robert Month 0440 Thomas 2011 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death **Examiner** 4c. County of Death University of maryland, snock Trauma Baltimore Baltimere 6. Sex If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Month, Day, Year) in • 8, 1922 1 👿 M 2 🗆 F Days Min Hours Yrs. 217-14-5306 89 Maryland Director Jan. Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location items 23a or 28a-f sho ner must be notified at 10d. Inside City Limits Director 1 XYes 2 No Maryland Crisfield Somerset 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country Funeral 136 N. Somerset Avenue 21817 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Examiner Was Decedent Ever In U.S. Armed Forces?
1 ☑ Yes 2 ☐ No 1944—
If Yes, Give
Year or Dates. 1946 Black, White, etc. ö þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: "natural", Specify. White 3 Widowed 4 Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Carpentry n and Mental Hygier Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Edward Thomas Timley Ann Kirkland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Barbara Dougherty (Daughter <u> 10214 Friendship Rd. - Berlin. MD 21811</u> Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) St. Paul's Cemetery 11/01/2011 Marion Station, MD Signatur f Furnal Savine zuen en

Mary Beth Bradshaw-Prui 22. Name and Address of Facility BRADSHAW & SONS FUNERAL HOME 306 W. Main Street - Crisfield, MD 21817 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Hemorrhage Onset and Death Physician/ Subdural disease or condition Medical resulting in death) Examiner 36 hrs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine CERTIFICATION APPROVED BY MEDICAL EXAMINER Cause (Disease or linjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): ending physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Ď Pregnant at time of death Month Day Year the a signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has I page 2 s autopsy this certificate 1 Yes Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 🗌 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of injury (Month, Day, Year) 10 26 2011 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer ☐ Natural 5 \square Pending Fall down steps 1 Yes 2 No un known M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 136 N. SOMETSET AVE, CRISFIELL MD 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, 18918 28/2011 Kim/benucle, mp XCA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Green St, Baltimore MD 54 University of Maryland MD 2/201 31. Date filed (Montl State NOV 01 201 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 2:16 AM November Medical Dean Turgeon 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospice House of St. Mary's St Mary's Callaway If Under 1 Year Months Days If Under 24 Hrs **Funeral** Age (In yrs. last birthday, 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 😾 F Hours Min 11/11/1938 New Jersey **Director** 520-44-4599 73 Usual Residence of Decedent or 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director 1 🗌 Yes 2 ី No Maryland St. Mary's Hollywood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 24524 Half Pone Point Road 20636 United States or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2XX No Black White etc þ 1 Never Married 2 X Married Maryland 21215-0036 White 1 ☐ Yes 2 No Specify I Hygiene. other than "natural", If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Editor Newsletter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of Frances Dean Smith Maurice Dudley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Charles Frederick Turgeon-Spouse 24524 Half Pone Point Rd., Hollywood, MD. 20636 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 2011 any injury or Brinsfield-Echols Charlotte Hall, MD. 4 Donation 5 Other (Specify) November 6 21. Signature of Funeral Service Oceanies Antivacci Kathleen A. Santivasci M00872 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) mes months cancer Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine and -transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): nding physician use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 Yes 2 No ☐ Live Birtn ∠ ☐ 1 600 000 ☐ Pregnant at time of death ☐ Unknown Month Day Year signed by the a 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsv Yes 2 No 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🔀 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending injury work? Natural 5 Pending Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 🛮 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year)

(4) RME

State Registrar

ame

Jeffrey Brown, 26840 Point Lookout Road, Leonardtown, MD M.D.

nd address of person who completed cause of death (Item 23a) (Type, Print)

D42597

11-04-2011

11-08147 James Franklin Tir	nel		or Print in B										
James Hankiii Hi	1	- For State	e or Maryland		ificate d			a Meni	ai nygierii	₽ Reg.)	1 3681
Physician	7	Registrar 1. Decedent's Name (First, Middle,L	ast)							of Death		3	3. Time of Death
Medical Examine		James Franklii 4a. Facility Name (if not institution, o				I dh. Citu	Town or	Location o		ber 31,	2011 4c. County of E)eath	0000 hrs
	Are was	24475 Mervell Dean Roa		,			ywood	Location o	Death		St. Mary's	, eati	
Funeral	1	5. Social Security Number 6.	Sex 7. Ag	je (in yrs. las	t birthday)		der 1 Yea			e of Birth(I	MM/DD/YYYY)	9. Birthi oreign	place (State or
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and a	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loc	ation						1	Od. Inside City Limits
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the Maryland a nr 28a-f show tiffed at once.		10e. Street and Number	, -			10f, Zi	ip Code			10g.	Citizen of What	Countr	y?
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leath with r items 23 aust be no		11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent	?					in? (Specify Yes Puerto Rican, et		14. Race - A White, e		in Indian, Black,
after de			ed If Yes, Give Year	X No	1	Yes 2	2X No	specify:			Specify:	Whi	te
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5-0036 state of white the control of the control o		Elementary/Secondary (0-12)	College (1-4 or		Const	ruoti	on U	orkor			onstruc	tio:	n
21215-0036 uld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	\$	17. Father's Name (First, Middle, La	st)		JOHSEI	Lucti			s Name (First, M			LIO.	11
121 d be fill ental F arked vent, i	3	Fred Rudolph Ti	nsley		T			Agnes	Cyrill	a Woo	od		
MD 21 nd 2 should alth and Mes m 27 is man TO	<u>'</u>	19a. Informant's Name/Relationship Agnes C. Tins1e									r, City or Town, S		
e, M		20a. Method of Disposition			ace of Dispo	osition (Na	ame of ce		Date		Oc. Location - Ci		20636 own, State
MOF Pages ent of l ut; If	-	1 Burial 2 X Cremation 3 4 Donation 5 Other Speci		4.0	ematory or o	•		Cro	11/04/2	011	harlatt	. A E	Iall MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 bours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a nr 28a-f shun injury ar other traumatic event, the Medical Examinet. must be notified at once. To Re Completed by Finneral Director	21. Signature of Funeral Service Moeneee 22. Name and Ad										Funeral		
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760, cate be physici he buri		F FEMALE:	23c. If yes, outcor	ne of pregna	incy					I	23d. Date of de	livery	
). Box 68760, the death certificate be executly the attending physician any check for use as the bunal - transportation.	2	3b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at	time of deat		Fetal death Other (Spe		Ectopic	pregnancy		Month	Day	y Year
BOX 6		1 Yes 2 No 9 Unknow	vn 9 Unknown		2 □ (other (Spe	ecity)			-			
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COTC law re- has be 2 sho									_ _	autopsy performe	prio	r to cor	npletion of cause of
Rec ificate Con	chronic alcoholism chronic alcoholism 25. Was case referred to medical 26. Place of Death (0)									Yes 2	No 1 ✓	Yes	2 No
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of Vi		27. Manner of Death	28a. Date of Inju (Month, Day,Y	iry 2	8b. Time of	f Injury	28c. Inju	ry at Work?	28d. Des	scribe how	injury occurred		
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C Fill		4 Homicide	ician: To the best of m	y knowledae	, death occ	urred at th	e time, da	ate and place	ce, and due to th	e cause(s) and manner as	stated.	
To the Ho within 24 To the Fu complete!		Oncor oray	er: On the basis of exa and manner stated.	-				-					
F S F S	1	29b. Signature and title of certifier				29	c. Licens	e number	DOME	29	d. Date signed	(Month	, Day, Year)

State Registrar DHMH 17 Rev 1/2001 OCME 2006 32. Regis ar's Signature

30. Name and address of person who completed cause of death/(Item 23a)

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

O.C.M.E.

Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

October 31, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36847 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 27 October Da Physician/ 7:30am Edna Lucille Taylor Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Renaissance Gardens - Riderwood Prince George's Silver Spring | If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) | April 24 9. Birthplace (State or Foreign Country) Alabama Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗓 F Director 422-44-9691 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 804 Windmill Lane 20905 U.S.A. death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🖸 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 X Never Married 2 Married Completed by within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 K No Specify: Specify. 3 Widowed 4 Divorced Caucasian Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical. 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Federal Government Sec<u>retary</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, John Miller Taylor Edna Mean Watson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 804 Windmill Lane, Silver Spring, Maryland 20905 Linda T. Arthur - Sister Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 💢 Removal from State Pineview Memorial 11/05/2011 Valley Grande, Alabama 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22, Name and Address of Facility Hines-Rinaldi Funeral Home, 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death
Years Immediate Cause (Final Physician/ Atherosclerotic Cardiovascular Disease disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to in reciate Due to (or as a nonsequence of) if any, reading to immedia cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial. Tagett Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🕱 No Month Year Day Pregnant at time of death 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Dementia 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 XI Nursing Home 5 - Residence 6 - Other (Specify) 2 🗶 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Gertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 15 D24035 October 27, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Eugenio Machado,

NOV 0 2 2011

31. Date filed (Month, Day, Year)

M.D.,

Registrar's Sign

3110 Gracefield Road, Silver Spring,

Maryland 20904

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 30, 2011 4:20pmM Alberico Bello Umali Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Bethesda Suburban Hospital Social Security Numbe If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 8. Date of Birth **Funeral** (Month, Day, 1 **X** M 2 □ F Months Hours Philippines **Director** 1953 58 Jan. None Usual Residence of Decedent or 28a-f show notified at with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Philippines Mandaluyong 10e. Street and Number rms 23a or ò 10f. Zip Code 10a. Citizen of What Country? Funeral 1550 815 A Mabini Street Philippines r than "natural", or items the Medical Examiner mus should be filed within 72 hours after death v and Mental Hygiene. 'is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married è Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. Specify: Filipino Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Lega1 Lawyer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) traumatic Vicente Umali Elenita Bello 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Page 1 and 2 815 A Mabini Street, Mandaluyong, Philippines 1550 Criselda DeCastro Umali (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Nov. 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State Tiaong, Quezon Phillipines Tiaong Catholic 4 Donation 5 Other (Specify) 2011 DeVol Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Acute Myloleukemia Medical Due to (or as a consequence of) **Examiner** Sepsis Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) sician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical The law requires that the death certificate be Box 68760 the use as IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 00 Month Year Pregnant at time of death 5 Other (specify) the 0 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Page 2 s has autopsy performed? death? this certificate 1 ☐ Yes 2 ☐ No the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 1 No မ 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 □ Yes 2 □ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of ificate: 28d. Describe how injury occurred Q 5 Pending X Natural within 24 hours after death. To the Funeral Director: A ☐ Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined 9 City or Town, State) cal 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 0 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, 10/31/11 MO7288 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LEIGN BLOO OLD GUVAR

Registrar

DHMH 17 Rev 7/2009

State

ALBERICO

8600 Old Georgetown Road Bethesday MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Michael Steven Vandling State of Maryland / Department of Health and Mental Hygiene 36849 2011 1- For State Certificate of Death Registrar Rea No. Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Medical Examiner MICHAEL STEVEN VANDLING 1803 hrs November 11, 2011 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 204 Cockey Lane Stevensville Queen Anne's 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Director Months Days Hours Min 230-17-9663 1X M 2 F 43 FEB. 5, 1968 Country) OHIO Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show QUEEN ANNE'S STEVENSVILLE 1 Yes 2 X No with the Maryland Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 204 COCKEY LANE 21666 USA Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 2 X No 1 Yes Pages 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene.

tant: If item 27 is marked other than "natural", of or other traumatic event, the Medical Examiner B. 3 Widowed 4 X Divorced If Yes, Give Year WHITE 2 X No specify: Yes ۵ Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 MUSICIAN ENTERTAINMENT 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be DONALD DAVIS VANDLING LINDA KAY GASSAWAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LINDA LOCKNER/ MOTHER 1414 SCANLAN DRIVE, GLEN BURNIE, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State NOV.13, tment o APEAKE CREMATION STEVENSVILLE, MD 4 Donation 5 Other Specify: 2011 permit.
Departm
Importa 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN
106 SHAMROCK ROAD, & NEWNAM FUNERAL HOME, P.A. CHESTER, MD 21619 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval failure. List only one cause on each line. /Medical Between Onset and a. Cardiac Arrhythmia Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): b. Cardiomegaly with left Ventricular Hypertrophy Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical X UNPENDED AMENDED 23a-b, pt. II, 27, per me, g921 11-22-11 sm e attending physician for use as the burial Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, P. Cocaine, oxycodone and hydrocodone use 1 Yes 2 No 3 Probably 4 ✔ Unknown Completed director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy this certificate has prior to completion of cause of performed death? ✔ Yes 2 No 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other Scene 1 🗸 Yes No After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Pending 1 Yes 2 No Accident 2 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 28f. Location (Street and Number or Rural Route Number City Suicide Could not be determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number O.C.M.E. November 12, 2011 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) NOV 14 2011

State Registrar 32 Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36850 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Brenda Faye Wathen 2011 November 5:20p ^M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death St.Mary's Hospice House of St. Mary's Callaway Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Months Hours 10/05/1954 57 Director Maryland 579-78-0230 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No St.Mary's Mechanicsville Maryland within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 37444 East Lakeland Drive 20659 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married \$ ☐ Yes 2 🛛 No Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify 3 ☐ Widowed 4 🖾 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Office Manager MD State Highway Admin. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Francis McQue Lawrence Rosemary Norris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Kristie Covington/ Daughter 5821 Long Beach Drive, St. Leonard, MD 20685 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Charles Memorial Grd. 11/14/2011 Leonardtown, Maryland Name and Address of Facility Mattingley-Gardiner Funeral Home, P 41590 Fenwick Street, Leonardtown, 21. Signature of Funeral Service Lic мД° 20650 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on e.c. line. dying, such as cardiac or respiratory arrest Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any leading to immediate cause. Enter Underlying ending physician and use as the bunal-transit requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No for 5 Other (specify) Month Day Year Pregnant at time of death signed by the a 1 ☐ Yes ☐ 9 ☐ Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ has been signe 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Hospital or Attending Physician; The law page perform After this certificate 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 5 \sum Residence Hospital 1 🗌 Yes 2 X No 욘 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 24 hours after death. Funeral Director: A 1 ☐ Yes 2 ☐ No Investigation the 3 Suicide 4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or inventioning in any control of the cause Medical (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Number Practiciner To the best of my knowledge, and the number of the first opinion of the cause(s) and manner stated within 2 To the I 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Jennifer Schmidt, D.O., 40900 Merchants Lane, Suite 205, Leonardtown, MD 20650 31. Date filed (Month, Day, Year, State NOV 0 9 2011 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2011 36851 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ November 5, 2011 Wilson Helen 3:45a.M Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 22680 Cedar Lane Ct. Apt. 1216 Leonardtown St. Mary's . Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday Birthpiaco, Country) PA. **Funeral** 1 M 2 X F Days Marth 237 1925 204-12-6715 86 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits at 10a. State 10c. City, Town or Location Director must be notified 1 Yes 2 No Leonardtown MD St. Mary's 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral United States Apt. 1216 20650 22680 Cedar Lane Ct. or items death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Specify: White 3 X Widowed 4 □ Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 12 yrs. Homemaker Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Margaret Cecelia Purcell Martin Horn Morrison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hampstead, MD. 3915 Sunset Dr. <u> Martin John Wilson / Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🛣 Cremation 3 🗆 Removal from State Brinsfield-Echols Cre. 11/09/2011 Charlotte Hall, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Some and Address of Facility 22955 Holl

Margafet H. Hicks M01631 Brinsfield Funeral Home

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hollywood Rd. Approximate Interval Between Fzilure to Inset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Dien to for es a nonscourren ofi cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lifled in by the huneral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 XNo Month Pregnant at time of death 1 Yes 2 D 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 XNo Other: 4 \(\sum \) Nursing Home 5 \(\frac{\mathbf{X}}{\mathbf{X}}\) Residence 6 \(\sum \) Other (Specify) 1 Yes ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 29a. Certifier 1 XX certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the sets of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) DO052196 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

J Scott Tidball, M.D.

NOV 0 7 2011

31. Date filed (Month, Day, Year)

6) Rme

23415 Three Notch Road

Registrar's Signatur

20619

California, MD

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	Examin		4a. Facility Name (if not institution, giver Casey House	e street and number)		4b. City, Town, q Rocky	r Location of E	Death	- 1	. County o		
B.	Funeral		5. Social Security Number 6.3	Sex 7. Ag	je (In yrs. last birthday		If Under 24		irth	Ĭ		nplace (State or Foreign
li.	Director		116-16-7451 Usual Residence of Decedent	1 x M 2 □ F	Yrs.			11-2	1-19	25		NY
	/land f show ed at	tor	10a. State 10b. County		10c. City, Town or I							10d. Inside City Limits
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	with th	Funeral Director	12830 Littleton	ST		20906			USA		181 000	and y :
	items items		11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13	B. Was Decedent of H If Yes, specify Cuba	lispanic Origin an, Mexican, F	? (Specify Yes or No Puerto Rican, etc.)	-		- Ameri	ican Indian,
36	after al", or Examin	d by	1 ☐ Never Married 2★☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 If Yes, Give	1964	1 ☐ Yes 2 🛣 No				Specify:		ite
2-00	hours natur	plete	15. Decedent's (Specify only highest g		16a. Dec	cedent's Usual Occup ve kind of work done	during most of	f working	16b. k	Kind of Bus		
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4 or	5+) Selfi	LOONOT use retired of Petty O			U.	S. N	lavy	
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P.O.	that th	y Ph	Part II. Other significant conditions	contributing to death i	out not resulting in the	e underlying cause gi	iven in Part I.	23e. Did	tobacco	use contri	bute to	the cause of death?
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	To the Hospital within 24 hours a To the Funeral Completely filled	Medical	(Check 2 Medical Exar	nysician: To the best of miner: On the basis of earse Practitioner: To the	examination and/or inv	estigation, in my opini	ion, death occu	irred at the time, date	and plac	e, and due	to the c	cause(s) and manner stated.
			29b. Signature and title of certifier	<u> </u>		29c. Licens						n, Day, Year)
	103		1 John	1XX		D371	42		10/	/20/2	011	
			30. Name and address of person who Geffrey Coleman				0 Rockv	ville, Md	2085	50		
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رادسور جوست	Examin	er	4a. Facility Name (if not in Holy Cross	Hospit	tal			4b. City, Town, Silver	Sprin	g			gomery		
P.	Funeral Director		5. Social Security Number 244-30-7154 Usual Residence of Dece	4 1	7. Age	(In yrs. last b	oirthday) Yrs.	If Under 1 Yea Months Days			8. Date of Birth 10–25–25.	1926	9. Birth Coun Nort	h Caro	or Foreign Olina
	Maryland 28a-f show otified at	Director	10a. State 10b.	County	ery	10c. City, To								10d. Inside Ci	ty Limits
	s 23a or anst be no	Funeral D	10e. Street and Number 3124 Grac	efield	Road Apt#	KC 40)1	10f. Zip Code 209 (10g. Citize USA	n of What Coul	ntry?	
9800	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show er than "natural", or items 25a or or 28a-f show, the Medical Examiner must be notified at	þ	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ [Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 If Yes, Give 19 Year or Dates.		lf lf	Vas Decedent of Yes, specify Cul	oan, Mexicar	i, Puerto Ri	fy Yes or No- can, etc.)		. Race - Americ Black, White, pecify: Afro	etc.	•
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Balt	permit. Depart Import any inj		21. Signature of Funeral S	Service Licens	Clyhun	v-cc0	521 7	Name and Add CGuire 1 400 Geo	ess of Facility Punera Gla A	1 Ve. N	wice Wash	Inc ingto	n, D.C.	20012	2
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Division of Vital Records,	2 3S	Completed									24a. Was a autop perfor	sy med?	24b. Were auto prior to co death? 1 \(\sum Yes	ompletion of	available cause of
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Divisio	e Hospital or Attend 124 hours after death E Funeral Director A leted filled in by the f	O		Could not be determined			, farm, stre	eet, factory, office	9	21	8f. Location (S City or Tow		Number or Rura	l Route Num	ber,
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	To the To the Comple		29b. Signature and title o	_	Luda	<u> </u>			36716				signed (Month, r 29, 2		
			30. Name and address of Andrew Kun	person who c					Silve	r Spr	ing, M	209	04		
	Sta Registra		31. Date filed (Month, Day	0 2 201	32. Registra	r's Signature	par	Ked.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Physicia Medic		1. Decedent's Name (First, Middle, L MARY WARI	,						2. Date of Dear	D- 0/3	Year	3. Time of Death
-	Examir		4a. Facility Name (if not institution, g.	ve street and number)			4b. City, Town, o	MORE		-	4c. County	of Death	
	Funeral Director		213-56-3708	Sex 1 □ M 2 🛂 F	ge (In yrs. Ia	as <i>t birthday)</i> Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth 05/12/		9. Birthplac Country)	ce (State or Foreign VA
	aryland a-f show fied at	ector	Usual Residence of Decedent 10a. State 10b. County MD MONTO	GOMERY		, Town or Loc	ration RSBURG					10d	I. Inside City Limits
	with the M 23a or 28 ist be noti	Funeral Director	10e. Street and Number 18814 WALKERS	CHOICE	RD.		10f. Zip Code 2 (886			10g. Citizen of W	hat Country	
900	ge 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	Ş	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1			Vas Decedent of H Yes, specify Cub		gin? (Spec , Puerto R	ify Yes or No- ican, etc.)		- American k, White, etc	•
21215-0036	within 72 hou giene. ier than "nat i, the Medica	Completed	15. Decedent's (Specify only highest Elementary/Seconday (0-12) 8	Education grade completed) College (1-4 or	5+)	(Give H life. DC	ent's Usual Occup ind of work done ONOT use retired, ANING	during most	of workin	g	16b. Kind of Bu	TORI	
Maryland	d be filed Mental Hy arked ott	To Be	17. Father's Name (First, Middle, Las JAMES VICTOR								Maiden Surname; EFITTS		
, Mar	nd 2 shou ealth and m 27 is m	8	19a. Informant's Name/Relationship JAMES WARD /	(Type, Print) SPOUSE		19b. Mailin 1881	g Address (Street 4 WALKE	and Number IRS CI	r or Rural HOIC	Route Number, E RD.,	City or Town, St	ate, Zip Coo AITH	ERSBURG
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tr. once.		20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spe		, ce	emetery, crem	sition (Name of latory or other pla R CREMA	ce) TORY			20c. Location - 1 FRE	City or Town	
Balt	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Lice	nsee			. Name and Addre				P.O. BC BARNESV		, MD
	h sician/		23a. Part 1. Enter the disease, or co shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each lin	d the death le. RATI		r the mode of dyir			respiratory arre	est,	In O	pproximate Interval Between Inset and Death HOURS
	Medical Examiner	٠.	resulting in death)	Due to (or as	a consequ	ence of):	TUI NIF						
	cuted ind transit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events	Due to (or as						. 1	EXAMINER		
09.	cate be executed physician and the burial-transit	dical	resulting in death) Last	Due to (or as	a conseque	ence of):		CERT	FICATION	PPROVED BY M	EDIONE,		
. Box 687	ath certific attending for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 🗌 Fetal	Ideath 3 🗌	Ectopic pregnant Other (specify)					e of delivery th Da	
	requires that the des been signed by the s should be detached		Part II. Other significant conditions	contributing to death t	out not resu	ulting in the ur	nderlying cause gi	ven in Part I.			pacco use contri		cause of death?
of Vital Records,	The law ate has bage 2	Completed by								24a. Was ai autops perfori 1 Yes	sy p		r findings available pletion of cause of
Vital	ysician: The is certificate director, pag	To Be	25. Was case referred to medical examiner? 1 XYes 2 XVO	Hospital:	ient 2 🗆 8	ER/Outpatien	Oth	er:			ence 6 🗆 Other	(Specify)	
on of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific. completed filled in by the funeral director, I	Certificate:	27. Manner of Death 1. Natural 5 Pending 2 Accident Investigati	28a. Date of inju (Month, Da	iry :	28b. Time of injury	28c. Injur work	y at	28		w injury occurre		
Division	tal or Att		3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ury - At hor c. (Specify)	me, farm, stre	et, factory, office		2	Bf. Location (St. City or Town	reet and Number , State)	or Rural Ro	oute Number,
	the Hosp hin 24 hou the Funer npleted fil	Medical	(Check 2 Medical Franconly one) 3 Certifying No.	ysician: To the best of piner: On the basis of e practioner: To the	examination	and/or investi	gation, in my opini	on, death occ	curred at t	ne time, date an	d place, and due	to the cause	e(s) and manner stated. d.
	og wit		29b. Signature and title of codifier				29c. Licens	e number	196		9d. Date signed	(Month, Day	y, Year)
	Ц		30. Name and address of person with	completed cause of c							21201		
	Stat Registra		31. Date filed (Month, Cly Year) 2	00 1	ar's Signatu		and						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM#11perFH,G921,11/22/2011 WS State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month 4:20 PM RTHUR PAUI 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner DLNEY MONTGOMER HOSPITAL MONTGOMERY GENERAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Director 084-01-3111 1 XM 2 🗆 F 94 New Jersey Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ms 23a or 28a-f shormust be notified at Director Maryland Montgomery Silver Spring 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? Funeral 3701 International Drive #745 20906 United States permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No
If Yes, Give Black, White, etc. Never Married 2 Married ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: white 3 Divorced Completed Year or Dates. '42-'45 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Federal Government Management Analyst Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Nathan Adler Jennie Levy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elliott Adler, Son 9856 Avenel Farm Dr., Potomac, MD 20854 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Israel Cemetery 11/20/11 Woodbridge, NJ 21. Signature of Fune al Service Locen ee Forchandsky Hebrew Funeral Home 254 Carroll St., NW. Washington, 20012 23a. Part 1. Soto the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ PNEUMONIA BILATERAL disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner CONGESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of) ISCHEMIC attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant
9 Unknown Pregnant at time of death 5 Other (specify) 1 Yes 2 9 Unknown been signed by the a should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown CHRONIC KIDNEY DISEASE 24b. Were autopsy findings available prior to completion of cause of HYPERTENSION 24a. Was an cate has autopsy performed? death? 1 ☐ Yes 2 ₺ No this certificate 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Division of Vital director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certificate: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA completely filled in by the funeral 28c. Injury at work?
1 Yes 2 No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 24 hours after death. Funeral Director: After injury 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29d. Date signed (Month, Day, Year) D59418 NOVEMBER 17,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Dr. Olaev. Mp. 20832 AL OLIVE WISI ANEWUNMI, MD. MONTGOMERY GENERAL MOSPITAL 31. Date filed (Month, Day, Year) State arke Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. L. Decedent's Name (First, Middle, Last) 2. Date of Death .Month Physician/ Z049 Merson ovember 16.201 ichele Medical Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOPKINS The Johns HOS PITZU Balhmore City 8. Date of Birth (Month, Day, Year) Apr 04, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 6. Sex **Funeral** Days Hours Min 51 1960 Maryland Director 213-70-5193 1 🗆 M 2 💢 F Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at with the Maryland Director 1 Yes 2 No MD Baltimore Gwynn Oak 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 5900 Windsor Mill Rd. 21207 United States death v 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married چ و within 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 Divorced Black the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o ဂ္ Evelyn B. Barnes Page 1 and 2 should be Allen S. Amerson traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other tratonce. Michael Amerson /Brother 6541 Fairmount Ave. Baltimore, MD 21215 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Nov 4 ☐ Donation 5 ☐ Other (Specify) 2011 Beltsville, Maryland Chesapeake Crematory 21. Signature of Funeral Service Licensee 22. Nacramation Funeral Alternatives MO1585 Hobo 8717 Green Pastures Drive Towson Maryland 21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ subarachnoid Due to (or as a consequence of): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last attending physician and for use as the burial-trans Due to (or as a consequence of): Physician/Medical To the Hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death.

To the Funeral Director; After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the bur P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 2 🗌 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examine ? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 No ဂ 1 Patient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury 5 Pending work?
1 \sum Yes 2 \sum No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signatur rtifie 29c. License number 29d. Date signed (Month, Day, Year) SM son who completed cause of death (Item 23a) (Type, Print) Ballimore MOZIZET 600N solle st TUTTGE 32. Registrar's Signature State

Registrar

NOV 1 8 2011

back

11-08576 Marc Ira Albert

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State of Maryland / Department of Health and Mental Hygiene 36857 2011 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marc Ira ALBERT Month 0650 hrs **Medical Examiner** November 15, 2011 c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 600 East Gude Drive Rockville Montgomery If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** Foreign Months Days Hours Director 215-68-8162 1956Wastinaton. 1 X M 2 F 28 DC 55 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a, State 1 Yes 2 No s 23a or 28a-f show e notified at once. Maryland Montgomery Ashton with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 20861 17905 Ashton Club Way Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, altimore, MD 21215-0036
mit. Pages I and 2 should be filed within 72 hours after death variented? Betalth and Menall Hygiene.
portant: If item 27 is marked other than "natural", or item
ury or other traumatic event, the Medical Examiner must but Armed Forces? White, etc. 1 Never Married 2 Married 2 X No 1 Yes specify: white 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: 6 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Washington Post 12 Carrier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Bernice Sobin Be Alfred Albert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ဥ 117905 Ashton Club Way, Ashton, MD Melody Baggett, Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Metropolitan Crematory 11/17/11 Alexandria, VA 4 Donation 5 Other Specify 21. Signature Furjekal Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St NW. Washington. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line (Martica) Death a. Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Physician/Medical \square AMENDED 23a, pt. II, 27, per me, g922 12-15-11 sm X UNPENDED attending physician or use as the bunal Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy 1 Live birth Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 23e. Did tobacco use contribute to the cause of death? ۾ 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus; Liver Disease Completed 24a. Was an 24b. Were autopsy findings available certificate has been autopsy prior to completion of cause of performed' death? ✔ Yes 2 No 1 🗸 Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene this 1 🗸 Yes ဥ 28a. Date of Injury (Month, Day, Year) After 27, Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be determined (Specify) 4 Homicide 29a, Certifier 1 Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 16, 2011 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** John Paul Amoroso, Jr. 2230 November 14, 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Harford Memorial Hospital Harford Havre de Grace 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/11/1942 9. Birthplace (State or Foreign **Funeral** 1XM 2□ F Months Days Hours D.C. country 69 Director 136-34-0419 Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d Inside City Limits Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. Director Yes 2 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21015 1105 Jeffrey Terrance Apt. 1 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: white ģ 3 ☐ Widowed 4 🖾 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 sales retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental F should be John Paul Amoroso, Sr. ဥ Virginia Donohue 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 359 Woodland Green Court, Aberdeen, Maryland 21001 Dianne Amoroso (ex-wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State Pages 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) R.A.Ferris & Company 11/16/2011 West Chester, PA 21. Signatur of June al Service Lansee 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 ranco 23a. Part T. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final END STAGE CHRADIC OBSTRUCTIVE Physician disease or condition resulting in death) /Medical PULMONAMY DISEASE Due to (or as a consequence of): Examiner MONTH MERRI FAILURE LOPGESTIVE Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) burial-tran resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Vital 1 ☐ Yes 2 ☐ No 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred or Attending Division 1 Natural 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) November 15,2011 MO D71096 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) 5. UNION AVENUE HOURE DE GREW MO ANGELIM ESMOILLA 50\$ 31. Date filed (Month, Day; Year) - - -32. Recistrar's Signature 21078 State Registrar X DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36859 Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Anne Arundel Linthicum Tate Hospice House 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex **Funeral** Maryland 1 □ M 2 🗓 F Months Sept 7, Year 920 Director 91 219-01-1929 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at death with the Maryland Director 1 Yes 2X No Arnold Anne Arundel MD 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA Funeral 21012 596 Kevins Dr. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. white δ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates Specify Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry alth and Mental Hygiene.
27 is marked other than "I r traumatic event, the Med Elementary/Seconday (0-12) 12 Westinghouse stenographer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Roberta Gibson Ezra Oscar Holbrook 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important; If item 27 is any injury or other tra once, 596 Kevins Dr; Arnold, MD 21012 Rolane Petenbrink - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board Ron 655 W. Baltimore St; Baltimore, MD 21201 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock or heart failure. List only one cause on each line. Approximate Interval Between eset and Poath Immediate Cause (Final SEASE Physician/ N disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to incrediate cause. Enter Underlying Examine Due to (or as a nonsequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year signed by the atte Other (specify) g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy this certificate has al director, page 2 performed 1 Yes 2 🗌 No 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) examiner? ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 28a. Date of injury (Month, Day, Year) 27. Manne Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No funeral Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer Natural injury 5 Pending Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one 29b. Signature and title of certifier

DHMH 17 Rev 7/2009

State

Registrar

Name and address of person when the NEV EVE

1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year OT Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death A.A.CO 72 MAGOTHY BEACH ROAD PASADENA 9. Birthplace (State or Foreign Country) ege (In yrs. last birthday) **Funeral** If Under 24 Hrs. 8. Date of Birth Year Months Days Hours JUNE 27,1924 **Director** 236-32-2715 KY 1 🗆 M 2 🕞 87 Usual Residence of Decedent 10a. State at 10c. City, Town or Location 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified MD ANNE ARUNDEL **PASADENA** 1 X Yes 2 No 10e, Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral USA 72 MAGOTHY BEACH ROAD 21122 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. by 1 Never Married 2 Married within 72 hours after Baltimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 🙀 No Specify. Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 5 TEACHER **EDUCATION** Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည WILSON SHELTON WILLIE B. KYLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health attem 27 SUSTIN BENNETT/ SON 2773 BAKER ST. BALTIMORE. MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Page 1 permit. Page 1 Department of Important: If it any injury or o 1 ♥ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) cemetery, crematory or other place) ARBUTUS MEMORIAL PK. 11-22-11 BALTIMORE, MD re of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 701-31 LAURENS ST. BALTIMORE. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months
1 Yes 2 No Month Day Pregnant at time of death the g Unknown g Unknown Records, P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy Yes 2L 1 Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 21 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending injury ours after death. leral Director: A filled in by the fi Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. Homicide determined City or Town, State) within 24 hours a

To the Funeral C

completely filled Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, ause of death (Item, 23a Lenseltny ANNAPOLUS MOZIYUI

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year)

NOV 1 8 201

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36861 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOYGMB 5:37 P 10 Bohus Thomas Bata Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Buenie Medical Center Ariendel Glen ANNE. If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year)
May 24, 1930 Social Security Numbe If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F Months Czechoslovakia Director 218-28-7106 Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🗚No Anne Arundel Pasadena Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21122 610 Eliot Road 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc 1 ☐ Yes 2 🔀 No If Yes, Give ş 1 Never Married 2 X Married 8A+A Bohus Baltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify: Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (124 or 5+) Private Company Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Milstead Road Newport News, Va 23606 Niece Anne Ambrose 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Glen Burnie, Md 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 22. Name and Address of Facility Schimunek Funeral Home, Inc. 21. Signature of Funeral Service Licensee 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician FREBUIL IN SAZCI ISCULM'L disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Month 1 Yes 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death?

1 Yes 2 No autopsy Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident work?
1 Yes 2 No 5 Pending Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0055 NOUMBIN 10, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20 GLEN BURNIU.

Registrar DHMH 17 Rev 7/2009

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31. Date filed (Month, Bay, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deati Month / Physician/ Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Union Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Maryland 1**X** M 2 □ F Days August 29 ^{ar)}1928 **Director** 220-20-3796 83 Usual Residence of Decedent or 28a-f show 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Perry Hall Balto. Md. 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral and Mental Hygiene. is marked other than "natural", or items 23a. USA 21128 9827 Forge Park Road · death v 12. Was Decedent Ever in U.S. Armed Forces? 1X Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 XMarried Maryland 21215-0036 within 72 hours after White 1 Yes 2X No Completed Specify 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Westinghouse Electricial Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Ments Important: If item 27 is marked any fujury or other trees. pe Joseph Biscoe Helen Osakaska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9827 Forge Park Road Perry Hall, Md. 21128 Anna C. Biscoe Spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility / Schimunek Home, Inc. Funeral . Signature of Funeral Service Licensee Nottingham, Md. 21236 9705 Belair Road 23a. Part 1. Enter the disease, or com-shock, or heart failure. List only of ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine onsequence of Cause (Disease or lingury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be exec attending physician Physician/Medical use as the IF FEMALE 23c. if yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 4 Pregnant 9 Unknown Month Pregnant at time of death 5 Other (specify) 2 🗌 No the 9 Unknown Division of Vital Records, P.O. been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 ☐ No 3 🗶 Probably 4 ☐ Unknown director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 25. Was case referred to medical Certificate; To Be 26. Place of Death (Check only one) examiner? 2 12 No DAnpatient 2 🗆 ER/Outpatient 3 🗆 ĐOA 4 Nursing Home 5 Residence 6 Other (Specify) . Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 3 🗆 only one) 29b. Signature and title

State Registrar Day Year)

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month <u>Elsie</u> November 2011 3:35 AM Medical Mae Bailey 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Riverview Care Center Baltimore Essex Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Days Hours Min. 3/12/1921 Virginia 224-12-6278 Yrs Director 90 Usual Residence of Decedent 28a-f show 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits rector 1 ☐ Yes 2X No Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 72 Stemmers Run Road 21221 S. A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes 2X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify Completed 3 X Widowed 4 Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with h and Mental Hygien 7 is marked other tl 8 Seamstress Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Floyd Wassum traumatic James Carrie Burkette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Joey Karnes Bailey (Son) 72 Stemmers Run Road Essex, Maryland 21221 20a. Method of Disposition 20b Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory, Inc. 11/15/201 Baltimore, Maryland 22. Name and Address of Facility Bruzdziński Funeral Home 1407 old Eastern Avenue 21. Signature of Funeral Service Licensee Maryland 21221 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death mediate Cause (Final monur Physician/ EMSOLISM disease or condition Medical esulting in death) **Examiner** chous Sequentially list conditions, if dray, leading to thinned cause. Enter Underlying Exami emen Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events -tran and Due to (or as a consequence of) resulting in death) Last burialphysician s the burial Physician/Medical Box 68760 attending I for use as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Day Pregnant at time of death ed by the detached Unknown 9 Unknown P.O. signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy perform certificate Yes 2 XNo 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 🗌 Yes 2 🔀 No Other: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) this in 24 hours after death.

ne Funeral Director: After the pleted filled in by the funeral funeral 27. Manner of Death 1 X Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural
Accident
Suite 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar DHMH 17 Rev 7/2009

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

NOV 18 2011

only one)

cause of death (Item 23a) (Type, Print)

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Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Mace Avenue

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29d. Date signed (Month, Day, Year,

MD 21221

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36864 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ November 15, 2011 4:45 P Eva Louise Osborn Blass Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford 1103 Searay Court Abingdon 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1 ☐ M 2 🔀 F Days Hours Mir Director 101 1909 Pennsylvania 168-44-8564 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 Yes 2 X No Maryland Harford Abingdon 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1103 Searay Court 21009 death v items 11 Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ò 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates. 'natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed Specify: 3 Widowed 4 Divorced White Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve any injury or other traumatic eve once. ပ Hanibal John Christian Spires Alta Maude Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Ann Hyatt / Daughter 1103 Searay Court, Abingdon, MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X viurial 2 Demention 3 X Removal cemetery, crematory or other place) Other (Specify) Laurel Hill Cemetery 11-21-11 Erie, Pennsylvania Donation 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death MYOCARDIAL Physician/ disease or condition) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine Dise to for as a consequence of if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be P,O, Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the at d be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Division of Vital funeral director, 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 Mo ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director; After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director; /
completed filled in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29d. Date signed (Month, Day, Year) 11/16 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0

DHMH 17 Rev 7/2009

Registrar

NOV 1 8 2011

Tollgate Rd Bel Air, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Mar		tificate of		,	Reg. No. 2	110	3686
Physicia		1. Decedent's Name (First, Middle, La		ew			2. Date of De Month	Day	Year 2011	3. Time of Death
/Medic Examin	er	4a. Facility Name (If not institution, giv	ve street and number)		4b. City, Town, Baltimor	or Location of Dea	ath	4c. Count	y of Death	·
Funeral Director		,		n yrs. last birthday)	If Under 1 Year Months Day	r If Under 24 H		rth ay, Year)	9. Birth	place (State or Fore
		217-26-4825 Usual Residence of Decedent 10a. State 10b. County		0c. City, Town or Lo	ocation					10d. Inside City Lin
or 28a-f e notified	Director	Md 10e. Street and Number			Baltimor 10f. Zip-Code			10g. Citizen of		ntry?
of other than "natural", or thems 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	135 N. Kenwood A	Avenue 12. Was Decedent Eve Armed Forces? 1 □ Yes 2 🎇 No	er in U.S. 13.	Was Decedent of Yes, specify Cu	f Hispanic Origin? Iban, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	o- 14. Ra Bla	USA ce - Americ ack, White,	can Indian,
Hygiene. other than "natural", or Ite ant, the Medical Examiner	Ď	3 X Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	16a. Dece	1 ☐ Yes 2 📉 N		workina	Spec		White
grene. er than "n , the Medi	Completed	(Specify only highest green tary/Secondary (0-12) N/A	College (1-4 or 5+)	life.	Homemake	red)	Name (First, Midd)		Home_	
	To Be	17. Father's Name (First, Middle, Last James Yowell				M. g	ertrude :	Harrison	ı	- Code)
27 is		19a. Informant's Name/Relationship Robin Wooden	(Type. Print) DTI	3. 6	19 S. De	eet and Number or		1 to Md	212	24
		20a. Method of Disposition 1 XBurial 2 Cremation 3 4 Donation 5 Other (Spec	cify)	Morela	ematory or other p nd Memor	ial 11-	19-2011	Parkv	ille,_	Md.
Important: If any Injury or once.		21. Signature of Funeral Service Lice 23a. Part 1. Enter the disease, or con	K		6224 Ea	stern Av	enue Ba	lto.Md.		
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g phys as the	edical		d	Fetal death 3	☐ Ectopic pregn☐ Other (specify,				Date of deli	,
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 Perfn G922 12/09/2011 JH
State of Maryland / Department of Health and Mental Hygiene 36866 1 - State Registrar Certificate of Death Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ NOVEMBER 75, 2011 7:56 A DESPINA CALOS Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARFORD BEL AIR UPPER CHESAPEAKE MEDICAL CENTER 5. Social Security 1729 Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 1 M 2 😾 Months Days Hours Min. **Director** 213-62-6419 86 MAY 9 1925 WV Usual Residence of Decedent show 10a. State 10b. County at 10c. City. Town or Location 10d. Inside City Limits Director other traumatic event, the Medical Examiner must be notified items 23a or 28a-f 1 Yes 2X No MD HARFORD ABINGDON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral **IISA** 21009 3203 MEADOW VALLEY DR 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 14. Race - American Indian, 0. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 No Specify: Specify "natural", 3 X Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) OWN HOME HOMEMAKER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည MARY UNKNOWN GEORGE BUTERAKOS alth and ↑ 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 2226 WARFIELD DR FOREST HILL, MD 21050 ANTHONY CALOS-SON Department of Healt Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State GREEK ORTHODOX CEM. 11/19/11 WOODLAWN, MD 4 ☐ Donarion 5 ☐ Other (Specify) 21. Signatur Funer 22. Name and Address of Facility SCHIMUNEK FUNERAL HOME OF BELAIR Servine Licensee 610 W. MACPHAIL RD BEL AIR, MD 21014 Approximate Interval Between Onset and Death . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Severe So Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 2 days neumonia Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Box 68760 as the b yes, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy

Succeeds at time of death 5 Other (specify) IF FEMALE asn 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Year 1 Yes 2 g 9 Unknown Division of Vital Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy director, page 2 performed Yes 2 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ Inpatient 2 ER/Outpatient 3 DOA completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of M800307480 Certificate: 28c. Injury at 28d. Describe how injury occurred 5 🗆 Pending work?
1 Yes 2 No Natural injury Accident Investigation 3 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical 🛮 🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Continuing Number Practionar: To the best of my more wholes could not fine date and place, and due to the cause (s) and in a new 25 stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death ac 29b. Signature and title of certifier Internis 29c. License number 29d. Date signed (Month, Day, Year) 11/15/11 D66136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 Chosapeake DR BEL AIR MD 21014 Upper Uchendu 500 Nnenna 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

DESPINA

AL05,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For	State of Maryla				and Me	ental Hyg	giene				
			State Registrar		Cer	tificate of I	Death_			Reg. No.	201	4	368	6
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	Medic Examin		4a. Facility Name (if not institution, give str	eet and number)	,	4b. City, Town, o	or Location of		ovellibe		County of Dea		12:15 A	IVI
	Examin	er	Manor Care Silver			Silver					ontgom			
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	Director		223-40-4790	M 2 🖾 F 94	Yrs.	Months Days	Hours	J	(Month, Day une I c	, rea/19	17 Vir	gi	nia	
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36 after	ıl", or xami	d by	1 ☐ Never Married 2 ☐ Married . 3 🔀 Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☐XNo If Yes, Give	1	☐ Yes 2 🕅 No	Specify:			s	pecify: B1			
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filed	tal Hy ed oth event	To Be	17. Father's Name (First, Middle, Last)						irst, Middle,	Maiden St	ımame)			
<u>2</u>	l Men narke natic	-	Ernest Lynnwood Ja		-				cliffe					_
Maryland 21215-0036 2 should be filed within 72 hours after	if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	- 4	19a. Informant's Name/Relationship (Type Chester Lynwood Co		- 1	ng Address (Street Nora Dri							le)	
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Baltimore, permit. Page 1 and	Department of H Important: If ite any injury or ot once.		1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	hantill	natory or other pla Church	ce)				ntilly,			
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Spital	within 24 hours after death. To the Funeral Director. After this certifical completed filled in by the funeral director, to	ical	29a. Certifier 1 Certifying Physici	an: To the best of my kno	wledge, death o	occured at the time	e, date and p	lace, and d	lue to the cau	use(s) and	manner as s	tated.		
he Ho	in 24 ne Fu	Medical	(Check 2 Medical Examine)	r: On the basis of examinat Practioner: To the best of	ion and/or invest	tigation, in my opini	ion, death occ	curred at the	e time, date a	nd place, a	and due to the	cause	(s) and manner s d.	stated.
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	1		#8-	MD			4186	0/		11	114/	20	//	
	6		30. Name and address of person who com	mpleted cause of death (Ite	em 23a) (Type, F	Print)	711	P	+11	/	4x =	-	200	
	* Cto		31. Date filled (Month, Day, Year)	32. Registrar's Sign	nature (PA	ICA #	16-1	NOCK	11/18	<i>D</i>	- C	ك	76	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 13 Katherine 2011 Callahan 06:45 PM E. November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Y Feb. 08 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign Days Year) 1<u>919</u> 1 🗆 M 2 🗓 F Months Hours Min. Director 92 Yrs 214-26-4833 MD Usual Residence of Decedent or 28a-f shov notified at the Maryland 10a. State 10b. County 10c. City, Town or Location rector 10d. Inside City Limits 1 Yes 2 No Maryland Anne Arundel Millersville Ö 10e. Street and Number ò 10f. Zip Code 10q. Citizen of What Country? "natural", or items 23a o with 1 Funeral 488 Martin Drive 21108 USA permit. Page 1 and 2 should be filed within 72 hours after death be obsartment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner m. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. White 3 Widowed 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Household Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lemuel J. Jackson Mabel Goover 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda M. Woods (daughter) 488 Martin Drive, Millersville, MD 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 2011 4 Opnation 5 Other Metro Crematory Inc. Baltimore, Maryland Signature 22. Name and Address of Facility Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death cause on each line. Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes No
9 Unknown 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has factors after the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 2 to the funeral director, page 3 to the funeral director, page 3 to the funeral director, page 3 to the funeral director, page 3 to the funeral director director director. autops 1 Yes 2 No Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 🗌 Yes Other: 1 XInpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ._Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 \square Pending work? injury М Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c, License number 00044402

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (N

MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glen Burnie,

. Registrar's Signa

Hospital Drive,

29d. Date signed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Novembe /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) Age (In yrs. last birthday, 5. Social Security Number **Funeral** 1 □ M 2 🗓 K 46 3/24/1964 Georgia 219-84-3684 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shot amportant: If item 27 is marked other than "natural", or items 23a or 28a-f shot amp Injury or other traumatic event, the Medical Examiner must be notified at once, 1 ☐ Yes 2 ☐ No Director Kingsville Maryland Baltimore 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number USA 21087 12102 Bel Air Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 XMarried 1 ☐ Yes X No Specify Specify: White Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled 0 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last, Be Vonnie Jean Hardigree Libori Lingwai မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3823 Aldino Rd, Aberdeen, MD 21001 Mary Lingwai / Aunt 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition West Chester, 1 Burial 2X Cremation 3 Removal from State Ferris & Co. 11/15/2011 Pennsylvania 4 Donation Other (Specify) 22. Name and Address of Facility
Tarring-Cargo Funeral Home, P.A. 21. Signature 333 S. Parke St, Aberdeen, MD 21001 Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed physician and as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Month in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 □ No 2 No 1 🗌 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: Hospital: 3 DOA 1 Impatient 2 ER/Outpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tyes 2 WNo မ 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death Certification: Injury 1 Natural 5 Pending investigation 1 🗌 Yes 2 🗌 No M I Director: Af 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide 24 hours a Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2 To the

State Registrar

29b. Signature and title of certifier

NOV 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

32 Registrar's Signature

and manner stated.

Early

DHMH 17 Rev 1/2001

29c. License number

RES OOL

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

November 12,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Dav Month anford 1538 PM **Physician** 2011 15 November /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) May 2,6 1950 **Funeral** Days Hours Months North Carolina 61 239-88-4366 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f shov 1 ☐ Yes 2 ▼ No Director York Hanover Pa. 10g. Citizen of What Country? 10f. Zin-Code 10e. Street and Number U.S.A. 17331 120 Sara Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※ XNo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 21 If Yes, Give Year or Dates: American Indian 1 ☐ Never Married 2 X Married ٥ 1 ☐ Yes 2 🛣 No Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) other than vent, the Mex Elementary/Secondary (0-12) 12th College (1-4 or 5+) and Mental Hygiene. GAF Corp. Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernice Locklear James Clark ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 550 Family Drive Hanover, PA. 17331 Sharon A. Clark/ wife 27 20b. Place of Disposition (Name of cemetery, crematory or other place)
Meadowridge Mem. 20c. Location - City or Town, State November 20a. Method of Disposition Department of H Important: If ite any fnjury or ot once. 1 Burial 2 Cremation 3 Removal from State 18,2011 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facilitaczorowski Funeral Home, P. A M00933 21. Signature of Funeral Service Licensee Robert 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail for List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ASCVD Physician years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Examine Due to (or as a consequence of) The law requires that the death certificate be executed that initiated events nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) Yes 2 No P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 2X No 1 Tes 1 Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 R/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 5 Pending investigation 1 Natural Injury 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 \ Homicide within 24 hours a 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier November 16,, 2611 D 0067067 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ord 4940 Eastern Avenue, Baltimore, MD, 21224 haron 31. Date filed (Month) Day, Year) State NOV18

DHMH 17 Rev 1/2001 11595

Registrar

11-08476 Brian Albert Czajkowski

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2011 36871

		1- For State Certifica Registrar	te of Death	Reg. I	No.	
Physic	an/	Decedent's Name (First, Middle,Last)		Date of Death Month Da	av Year	3. Time of Death 1335 hrs
Medical Exam	ıner	Brian Albert Czajkowski 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	November 1	1, 2011 4c. County of Death	
		7934 Berk Lane	Rosedale		Baltimore Cour	nty
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho		- luno "	MM/DD/YYYY) 9. Birth	
Director		216-58-0181 1₹¥M 2□F 59	Yrs. Months Days Hours Min	24,19	52 Foreign	Maryland
_		Usual Residence of Decedent		1 - 1, 1 - 1		
w any		Md. Baltimore Ro	sedale			10d. Inside City Limits 1 Yes 2 X No
Maryland 28a-f show d at once.	혉	10e. Street and Number	10f. Zip Code	T 10g	Citizen of What Count	
or 28s	Director		21237	109.	U.S.A.	.,.
72 hours after death with the Maryland in "aatural", or items 23a or 28a-f sho sal Examiner must be notified at once.	멸	7934 Berk Lane 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (Sp		14. Race - Americ	an Indian, Black,
leath r r item	Funeral	1 Never Married 2 X Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.	
after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:			hite
5-0036 lied within 72 hours a Hygiene. I other than "naturs the Medical Exami	Pe	di	ecedent's Usual Occupation (Give kind of varing most of working life. DO NOT use reti		b. Kind of Business/In	dustry
36 in 72 than "	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 9th Lo	ngshoreman		I.L.A.	
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21215-0036 und be filed within ? Mental Hygiene. marked other that	Be (Frank J. Czajkowski	Lillia	an Bowen		
ID 21 should and Mei 7 is man	၉		Mailing Address (Street and Number or F 34 Berk Lane Ros			
nd 2 alth sm 2		1 3			Oc. Location - City or 1	
Baltimore, permit. Pages 1 a Department of He important: If ite		1 Burial 2 X Cremation 3 Removal from State cremator	y or other place) NO \	ember	-	,Maryland
Baltimo permit. Page Department of Important: injury or ott		4 Donation 5 Other Specify: Bay V 1 21. Signature of Funeral Service Licensee M(1) 933	ew Crematory 15	orowski	Funeral	Home PA
Balti permit. Departr Import		The state of rule and the control of the state of rule and the sta	1201 Dundalk Av	enue Ba	ltimore,	Md.21222
Physician	П	23a. Part I. Enter the disease, or complications that caused the death. Do not failure. List only one cause on each line. Dxycodone and	enter the mode of dying, such as cardiac of Paroxet ine Intoxica	r respiratory arrest,	shock, or heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a. <u>Atherosclerotic C</u>	ardiovascular Disea	se		Death
Axammer		or condition resulting in death) Due to (or as a consequence of):				
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence or).				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated				
ited d ansit		events resulting in death) Last Due to (or as a consequence of):				
Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. After this certificate has been signed by the attending physician and stely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical	AMENDED 23a,27,28a-	f,per me,g921 11-21	-11 sm		
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ox 687 sath certific attending	ian/	past 12 months? 1 Live birth 2 past 12 months? 4 Pregnant at time of death	Fetal death 3 Ectopic pregna	ancy	Month Da	ay Year
Box 68 e death certifi the attending ed for use as 1	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5	Other (Specify)			
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ords, w requir us been s	jet			24a. Was an autopsy	prior to co	opsy findings available empletion of cause of
Division of Vital Records, tal or Attending Physician: The law require is after dear. After this certificate has been si led in by the funeral director, page 2 should b	Completed by			performe 1 Yes 2 ₩		2 No
Vital Recysician: The I	Be C	25. Was case referred to medical examiner?	26.Place of Death (Check			
Physic r this	흔	1 ✓ Yes 2 No	patient 3 DOA Other Nursing me of Injury 28c. Injury at Work?	ng Home 5 Res	sidence 6 🗸 Other:	Scene
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Divisior Hospital or Attend 24 hours after death Funeral Director:	Certification:	- Galcide - Galarier se	dence	or Town, State Rosedale	7934 Berk Md.	Lane
D To the Hospital within 24 hours. To the Funeral		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	n occurred at the time, date and place, and	I due to the cause(s) and manner as state	d.
To the Hos within 24 h To the Fun completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or invand manner stated.				
	Σ	29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon	
		quise	O.C.M.E.		November 12, 20 	
•		Name and address of person who completed cause of death (Item 23a) Ana Rubio MD. Assistant Medical Examiner 900 W	. Baltimore Street, Baltimore, MI	D 21223		
	tate	51 0 1 5 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				
Regis		31. Date fled (Worth, Ballyoat)				

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 9 per FH, G922, 12/28/2011, WS

State of Maryland / Department of Health and Mental Hygiene 36872 Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Eugene Claude Delaney November 9, 2017 0921A Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 500 North Harry S. Truman Drive #217 Prince Georges' Landover 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours (Month, Day, Year) 06/01/1936 Maryland **Director** 219-34-8783 72 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No MD PG Landover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 500 North Harry S. Truman Drive #217 USA 20784 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces' Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Private <u>Bus Driver</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Eugene Claude Wilson Josephine Delaney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 4730 C Street, SE; Washington, DC Renato Delaney (Son) 20019 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State 11/19/2011 4 Donation 5 Other (Specify) Chesapeake Crematory Beltsville, Maryland 21. Sign (u) o Funeral Service License 22. Name and Address of Facility Freeman Funeral Services kendounc 4594 Beach Road; Temple Hills, MD 20748 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician, Chronic obstructive Pulmonary Disease Medical resulting in death) Due to (or as a consequence of): Examiner Tobacco use Sequentially list conditions, it any leading to immediate cause. Enter Underlying Examine Due to for as a consequence of ysician and s burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as the IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? detached for Day Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive sleep Apnea Completed 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown upleted filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ▼No 24a. Was an the Hospital or Attending Physician: The law thin 24 hours after death. autopsy Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 \square Nursing Home 5 X Residence 6 \square Other (Specify) Hospital 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred **X**Natural iniury 5 Pending work?
1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifier 1🚨 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 11.11.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Charles Read, M.D. 3800 Reservoir Road, NW; Washington, D.C. 20057 31. Date filed (Month, Day, Year) egistrar's Signature State 18 NUV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

-	.) Po o			
	State of Maryland	/ Department of H	ealth and	Mental Hygiene

2011 3	6	8	7	3
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nomas Duschei	1- For State	State	of Maryland / L	•	ite of Deat			2U1	1 35813
Physician/		ıme (First, Middle,Las					2. Date of Death	Dav Year	3. Time of Death 1628 hrs
Medical Examine		(if not institution air	Thomas		Dusche	Town, or Location of D	November	9, 2011 4c. County of Deat	
		pkins Bayview M			Baltir			N/	
Funeral Director	5. Social Security 217-02	-0677 ₁₂	ex 7. Age (In yrs. last birth	nday) If Und Month Yrs.	ler 1 Year If Under 2 ns Days Hours	Min. B. Date of Birth Dec . 3	(MM/DD/YYYY) 9. Bi Forei 0, 1977 Co	
yne	Usual Residence 10a. State	10b. County	10	Dc. City, Town o	or Location				10d. Inside City Limits
. ₹	MD	Ва	Ltimore				nda1k		1 Yes 2 No
with the Maryland us 23a or 28a-f sho be notified at once.		Number Ives Lane			10f. Zip	21222		g. Citizen of What Cou United	States
215-0036 be filed within 72 hours after death with the Maryland nutal Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once Rac Compulated by Funneral Director	11. Marital Statu 1 X Never Ma	rried 2 Married	1 Yes 2 X	ver in U.S.	If Yes, speci	ent of Hispanic Origin' ify Cuban, Mexican, Po XX No specify:	? (Specify Yes or No- uerto Rican, etc.)	White, etc.	rican Indian, Black,
urs afte	3 VVIdowed		If Yes, Give Year or Dates: only highest grade compl	eted) 16a. D	Decedent's Usual	Occupation (Give kin	d of work done	16b. Kind of Business	Thite Industry
5-0036 led within 72 hours lygiene. other than "natur the Medical Exami	Elementary/Si 12 Yea	econdary (0-12)	College (1-4 or 5+)	3	orking life. DO NOT us Operator			facturing
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical To Ra Commit	Thomas	ne (First, Middle, Last M. Dusch	el			Ma	Name (First, Middle, M ary B. Fior	ino	
Should and Me and Me natic ex		Name/Relationship (Type,Print) sehel(Fathe		Mailing Addres 7547 Ive	s (Street and Numbers Ses Lane Du	er or Rural Route Numl inda1k,Ma1	per, City or Town, States	e, Zip Code) 222
Ore, M ges 1 and 2 t of Health : If item 2 ther traur	20a. Method of I	Disposition	Removal from State	20b. Place of cremato	f Disposition (Na ory or other place	e)	Date	20c. Location - City o	
ultimit. Pagartment	4 Donation 21. Signature of	5 Other Specify Funeral Service Lice	nsee	Hillt	00 Mana	A Address of Espilitu	11/14/201		Maryland
Dep Dep	Jul	a Con			Duda 7922	-Ruck Fune Wise Ave	eral Home o Dumdalk	of Dundalk Maryland	
Physician /Medical	26a. Part I. Ente failure. List	only one cause on e					diac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner	Immediate Caus or condition res		Methadone and Due to (or as a consequence)		oin Int	oxication			
ted Insit	Sequentially list if any, leading to cause. Enter U (Disease or inju	o immediate nderlying Cause	Due to (or as a conseq	uence of):					
ed nsit	events resulting	in death) Last	Due to (or as a conseq	uence of):					
50, tre be executed systician and burial - transit	X UNPEND		AMENDED 23a,	pt.II,2	7,28a-f	per me,g9	23 1-20-12	sm	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of extension of the physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transition of the physician and th	IF FEMALE: 23b. Was deceded past 12 mor	ent pregnant in the hths?	23c. If yes, outcome 1 Live birth Pregnant at ti	2			pregnancy	23d. Date of delive Month	ry Day Year
b. Box 687(the death certification) by the attending phechof for use as the	1 Yes 2	No 9 Unknow	- L	me or death 5	Other (Sp.	ecify)			h
bhat the ed by the detached			contributing to death t	but not resulting	in the underlyin	ig cause given in Part		bacco use contribute to	
Records, P.(The law requires tha freate has been signed, page 2 should be det	Conge	nital Hea	rt Disease				24a. Was a	an 24b. Were a	utopsy findings available
COFC law re has be	<u> </u>						autop: perfor 1 ✓ Yes 2	med? death?	
a: The tifficate or, page		eferred to medical				26.Place of Death (C		2 No 1 🗸	res z No
Physician Physician This certical directo	examiner?		Hospital: 1 Inpatien	t 2 🗸 ER/00	utpatient 3			Residence 6 Oth	er:
on of anding Ph		5 Pending	28a. Date of Injury (Month, Day, Yes fd 11-9-	ar)	Time of Injury 3:36 pm	28c. Injury at Work?	1 .	now injury occurred	
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the star death. **All Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact stationary.	1 Natural 2 Acciden 3 Suicide 4 Homicio	6 X Could no	28e. Place of Inju	iry - At home, fa		ry, office building, etc.	28f. Location (S or Town, S Dundalk	tate) 7547 Ive :	Rural Route Number, City Lane .
Division of Vital Records, P.O. Box 6876 To the Hospital or Attending Physician: The law requires that the death certificat within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ph completely filled in by the funeral director, page 2 should be detached for use as the	_ 23a. Certiller 1	Certifying Physi	clan: To the best of my er: On the basis of exam	knowledge, dea	ath occurred at the	ne time, date and place ny opinion, death occu	e, and due to the caus	e(s) and manner as sta	ated. the cause(s)
To with	29b. Signature	and title of certifier	and manner stated.		2	9c. License number		29d. Date signed (M	onth, Day, Year)
	0-7	UL-	<u> </u>			O.C.M.E.		November 10, 2	2011
X		ddress of person who . Vincenti, MD	completed cause of de Assistant Medica	ath (Item 23a)	900 W B	altimore Street	Baltimore, MD 21	223	
Sta	-1 5 1 51 1 1	Month, Day, Year)	32. Registrar						.
Registra		NOV 18	2011 Janes	~ B	parla				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 5 per fh g921 11-28-11 vt
State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 11:35 NAM Patricia Gertrudis DeJulio November 15, 2**d**11 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson 8. Date of Birth
(Month, Day, Yea
Jun 12, Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. Social Security Numb 7. Age (In vrs. last birthday) 6. Sex **Funeral** 050-62-**6698** Days Hours Min Year 70 Director Panama 1 M 2 K 1941 show 10d Inside City Limits aţ 10a. State 10b. County 10c. City, Town or Location with the Maryland Director must be notified 28a-f 1 Yes 2 No York York 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Funeral 23a 131 South Hartley Street 17401 United States items death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 0 þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 □ No Spec Specify: 3 Widowed 4 □ Divorced "natural" Completed Hispanic <u> Panamanian</u> Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " event, the Med Elementary/Secondary (0-12) College (1-4 or 5+) Public School Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) id Mental F marked of 2 of Health and Menta fitem 27 is marked rother traumatic er Radcliffe Turner Lillian Eunice Aldridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Giselle Julio-Snyder /Daughter Balto., MD 21212 105 Dunbarton Rd. Apt. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a, Method of Disposition Nov 16 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Important: Is any injury or Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility M01443 Cremation and Funeral Alternatives 8717 Green Pastures Drive Towson Maryland 21286 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line multi Immediate Cause (Final nhe Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of pue burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis etely filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FFMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 Other (specify) 1 Yes 2 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a, Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 1 Tyes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred iniury Matural Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical To the Hospi within 24 hou To the Funer completely fil 29a. Certifier 🚧 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 2011 -6 AM 30. Name and address of pe son who completed cause of death (Item 23a) (Type, Print) VES 10 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 8 Parka Registrar

11-08541 Ross Edwards Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oss Edwards			tate of Maryla				d Mental F	lygiene		001	1 0007
¥		1- For State Registrar		Cer	tificate of	Death ————		2. Date of De	Reg. No.	201	3687
Physici ledical Exam		Decedent's Name (First, Midd ROSS Edward	ards							Year	2115 hrs
iculcal Exam		4a. Facility Name (if not institution		umber)	4	b. City, Town, or	Location of Deat			nty of Death	
		8200 Goodluck Road	-	,		Lanham			Prince	e George	e's
Funeral		5. Social Security Number	6. Sex	7. Age (in yrs. ia	ast birthday)	If Under 1 Yea	r If Under 24Hr	rs. 8. Date of B	irth(MM/DD/YY		thplace (State or
Director		579-58-0747	1X M 2 F	69	Yrs.	Months Day	s Hours Mi	n. 05/2	1/1942	Foreig	n thy)Carolina
	1	Usual Residence of Decedent	·A	0.5				1 03/2	1/1/12	1.01	ar carorina
*ny		10a. State 10b. County		10c. City,	Town or Location	on					10d. Inside City Limits
and show		MD I	PG		Land	over					1 X Yes 2 No
faryla 28a-f	ector	10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
th the Maryland 23a or 28a-f sho notified at once.	Dire	3430 Dodge Parl	< Road			20785	; ;		U	SA	
with ms 23	Funeral	11. Marital Status		cedent Ever in U.			spanic Origin? (S n, Mexican, Puert			ace - Ameri hite, etc.	ican Indian, Black,
death or ite	Ę	1 Never Married 2 N	1 Yes	2 X No						·	
raffer iner	ķ		vorced If Yes, Give Ye or Dates:			Yes 2 X No				№ Bla	
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examines	Peg	15. Decedent's Education (Spe Elementary/Secondary (0-12)		de completed) 1-4 or 5+)			tion (Give kind of . DO NOT use re		16b. Kind of	Business/	Industry
36 in 72 han '	Pe	12th	Conege (1~4 Or 5+)	Hondia	- Board	·onanowt	Danizzona	Colf		a
with giene	Completed	17. Father's Name (First, Middle	Last)		папитс	apped TI	ansport 18.Mother's Nam			Empl	.oyea
115.	BeC	Albert Edwards					Tiny]			,	
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygierd et et em 71 in marked other than "natural", or item 23a or 28s-fahe traumatte event, the Medical Examiner must be notified at once	70 E	19a. Informant's Name/Relation:			19b. Mailing	Address (Stree	et and Number or		mber, City or T	Fown, State	e, Zip Code)
MD d 2 sho lth and n 27 is		Ernestine Rodge	ers Edward	ds-Wife	3430 I	oodge Pa	rk Road	; Landov	ver, MD	207	'85
nore, MD 2 ages 1 and 2 shou nt of Health and N t: If item 27 is n other traumatie		20a. Method of Disposition			Place of Disposit crematory or oth		metery,	Date	20c. Location	on - City or	Town, State
nor ages ent of nt: If		1 X Burial 2 Crematio 4 Donation 5 Other S			dar Hill		ry 11,	/19/2011	Suit	land,	MD
Baltimore, MI permit. Pages I and 2 s Department of Health as Important: If item 27 injury or other traum.		21. Sun ture of F neral Servi	Licensee	7	22. Na	ame and Addres	s of Facility Fre	eeman Fi	neral	Servi	ces
ii ii Deg		yenda ya	Render				•	_	•		and 20748
Physician		23a Part I. Enter the disease o	complications that o	caused the death.	. Do not enter th	e mode of dying,	such as cardiac	or respiratory a	rrest, shock, or	heart	Approximate Interval Between Onset and
Medical Examiner		Immediate Cause (Final disease	a. Hypert	ensive A	Atheroso	lerotic	Cardiov	vasculai	Disea	se	Death
.xammor		or condition resulting in death)	Due to (or as	a consequence of	f):						
	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b. Due to /or as	a consequence of	f)·						
	턀	cause. Enter Underlying Cause (Disease or injury that initiated		a 001100 que 1100 0	•••						
sit id	Examiner	events resulting in death) Last	Due to (or as	a consequence of	f):						
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O, e be exe rsician burial -	edical	X UNPENDED				,			Tool D.	4) !!	
OX 6876 ath certificate attending phy or use as the b	N/L	IF FEMALE: 23b. Was decedent pregnant in t		outcome of pregi		al death 3	Ectopic pregr	nancy	23d. Date Monti	e of deliver h	y Day Year
x 6. h cert tendir use a	icia	past 12 months?	4 Pregi	nant at time of de		ner (Specify)					
BO; deatl the att	Physician/M	1 Yes 2 No 9 Ur	nknown 9 Unkn	iown							
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ires t sign d be d											bably 4 🗹 Unknown
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(eco) he law ate has	틸								ormed?	death? 1 ✔ Y	es 2 No
tal Rec	Bec	25. Was case referred to medica	al			26.Place	of Death (Check	k only one)	!		
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Division of Vital isla or Attending Physician: 13 after death. al Director: After this certiled in by the funeral director	Ë	27. Manner of Death	28a. Date (Mont	e of Injury h, Day,Year)	28b. Time of In		ry at Work?	28d. Describe	how injury oc	curred	
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ivis or Al Direc	≝	3 Suicide 6 Cou	uld not be 28e. Plac	ce of Injury - At ho	ome, farm, stree	t, factory, office I	ouilding, etc.	28f. Location or Town,		ımber or Rı	ural Route Number, City
Dital Ours a filled	Certification:	4 Homicide	ermined (Specify,)			 				
Division of Vital Records, P.O. Box 6876. To the Hospital or Attending Physician: The law requires that the death certificate Within 24 hours after death. To the Fureral Director: After this certificate has been signed by the attending play completely filled in by the fureral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying F	Physician: To the be aminer:On the basis	st of my knowled	ge, death occurr	red at the time, d	ate and place, an	nd due to the car	use(s) and mar	nner as stat	ted.
To th within To th	Medical		and manner	stated.	inavor irivestigati			acure unie, dat			
	2	29b. Signature and title of certifi	er	-		29c. Licens					onth, Day, Year)
		high	1,00	·		O.C.	IVI.E.		Novemb	er 14, 2	011
OK PLA		30. Name and address of person Ling Li, MD Assista	n who completed cau ant Medical Exa		•	e Street Bal	timore MD 2	1223			
V 1 V	1201			egistrar's Signatu		C Gueet, Dal	annoie, ivil 2	. 1229			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36876 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Claudia A. Emley November 16,2011 1:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Baltimore **Examiner** 4b. City, Town, or Location of Death Towson Gildhrist Center Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Days Hours 214-46-1855 Feb. 6,1944 Ohio Director 1 □ M 2 🗓 F 67 Usual Residence of Dec 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified Baltimore Carney MD 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? Funeral 23a USA 21234 2218 F. Lowell's Glen Road 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after dear Department of Health and Mental Hygiene. Important: If fem 27 is marked other trainment any injury or other trainment. Medical Examiner Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Ceridian Payroll and HR Apps. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mary Eileen Bussler William Jacob Luther 19a. Informant's Name/Relationship (Type, Print) 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 905 Osprey Way, Annapolis, Maryland 21409 Catherine McClung-sister 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Evans Fureral Chacel Cranation Ser. Belair 1 Burial 2 X Cremation 3 Removal from State Forest Hill, Maryland 18,2011 4 ☐ Donation 5 ☐ Other (Specify) . Signature of Funeral Service Licensee 22 Name and Address of Facility Papel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 tadal Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Interval Between anchesti Immediate Cause (Final Onset and Death Ph_sician/ Cances mentis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-trar Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 10 months?

1 Yes 2 No 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Day Year Pregnant at time of death detached the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by pe Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No After this certificate 1 Yes 2 No **Division of Vital** To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury 1 Natural work?
1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗲 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier

Registrar

DHMH 17 Rev 06-2011

State

31. Date filed (Month, Day, Year)

NOV

8

Registrar's Signature

18701 N. Charls ST Tarson MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene For State Registrar 36877 Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCCOBER RITZ ESONGAMI 8:22 AM JOL Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMER AKOMA PARK WASHINGTON HAVENTIST HOSPITAL 5. Social Security NumberUNK If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 XM 2 □ F Months Hours Min. 6/6/1968 Limbe Cameroon 43 **Director** Usual Residence of Deceden show 10a. State 10b. County 10d. Inside City Limits within 72 hours after death with the Maryland 10c. City, Town or Location notified at Director 28a-f 1 X Yes 2 No MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a or Examiner must be ı Funeral 20904 Cameroon 11700 Old Columbia Pike #713 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11, Marital Status Armed Forces?

1 Yes 2 XNo Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 Black 1 ☐ Yes 2XX No Specify: If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) 3 2 should be filed within 72 alth and Mental Hygiene.
27 is marked other than "I traumatic event, the Mec Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employeed Private 2th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Lotonge Sussana Mojoko Lotonge permit. Page 1 and 2 should be Department of Health and Mem Important: If item 27 is marke any injury or other traumatic s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11700 Old Columbia Pike #713 Silver Spring MD 20904 Alfred Ngha Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 KRemoval from State Doula, 4 ☐ Donation 5 ☐ Other (Specify) Cameroon Unk Doula, Cameroon 22. Name and Address of Facility Johnson & Jenkins Funeral Home 21. Signature of Funeral Service Lo 716Kennedy ST NW WDC 20011 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Ph_sician/ EVERE ACTIC ACIDOSIS Medical resulting in death) Due to (or as a consequence of): Examiner CQUIRED IMMUNE DEFICIENCY SYNDROME Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Dav Year Month 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by /MPHOSARCOMA 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No this certificate has 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: ၉ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural iniury 5 Pending Accident Investigation after death Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D0069051 , ma 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 7600 CARROLL AVENUE, TAKOMA PARK, MD. WIREOU ATDOO 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar NOV 1

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36878 Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death Physician/ Frederick William Entz, Jr. 5:43 A M Nov. $1.\overline{3}$ 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Riverview Nursing Home Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min (Month, Day, Year) Director 166-24-7411 1 ▼ M 2 □ F 79 July 7,1932 Pennsylvania Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director MD Baltimore Dundalk 1 Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a Funeral 7320 Kirtley Road 21224 United States death \ 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 XYes If Yes, Give 2 No Maryland 21215-0036 72 hours after 1 Yes 2X No Specify: Specify "natural", Completed 3 X Widowed 4 Divorced Year or Dates. Korean White event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) Police Officer 11 Years Law Enforcement and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elizabeth C. Boyle Frederick W. Entz, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is r. any injury or others 7320 Kirtley Road Dundalk, Maryland Catherine A. Gencel (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Parkwood Cemetery 11/16/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) uneral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear fathers. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Dementia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner DISCASE -KINS>NS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Uniterlying Cause (Disease or injury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical Records, P.O. Box 68760 inding pluse as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ jo in the past 12 months? Month Day Year Pregnant at time of death 2 No ed by the a detached t 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autons page certificate 1 Yes 2 No Yes 2 No Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 No 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work?
1 Yes 2 No To the Hospital or Attendin, within 24 hours after death.

To the Funeral Director: Aft completely filled in by the ful M Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of death (Item 23a) (Type, Print) Butimore MD 21221 1124 Mace cc. Avenue 31. Date filed (Month State Registrar

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

UNEGRUIMD

NOV 1 8 2011

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registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

2835 SMITH AVE SLITE 203 BACTIMORE, MD

29d. Date signed (Month, Day, Year)

2011

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Physicia Medic Examir **Funeral Director** 0.0.0. 10|29|2011 36,390,35 0.0:0330 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. Baltimore, Maryland 21215-0036 Physician/ Medical Examiner Known to Physicians as: Sauly Frey To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760

			Type or Pri					-		_	jible.	
•	For Ar State Registrar	mend Item	State of M	aryland / l	Depa Ce l	artment of J 9921, I tificate of	lealth and 1/18/20 Death	Mental F L Idhb	lygier _{Reg.}	ne No. o c		26000
n/	1. Decedent's Name	e (First, Middle, Las						2. Date of Month Octol		Day 29, 20	O I I	3. Time of Death 3:30 AM M
er	4a. Facility Name (if	not institution, give				4b. City, Town, o	r Location of Dea	th		4c. County Free	of Death	:k
	5. Social Security Nu	ımber 6. S	ex 7. Ag	e (In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		Birth	37)		place (State or Foreign
	511-12-3 Usual Residence of	12/4	□м 2 💢 F	86	Yrs.	WOITIS Days	110013	Nov 2	7°, 1	[924]	Kan	sas
ctor	10a. State	10b. County		10c. City, Tow								10d. Inside City Limits 1 ☐ Yes 2 X No
Dire	MD 10e. Street and Nun	Frederi	.ck	FI	eae	10f. Zip Code			10g.	Citizen of	What Cou	
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Completed by Funeral Director	11. Marital Status1 Never Marri	ed 2 Married	12. Was Decedent I Armed Forces? 1 \sum Yes 2 \sum X			Was Decedent of H	an, Mexican, Pue	rto Rican, etc.)	No-	Blac	ck, White,	
eted	3 X Widowed	15. Decedent's E	If Yes, Give Year or Dates.	160		1 ☐ Yes 2 🔀 No			140		whi	
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Be C	12 17, Father's Name (F	First Middle Leath	1			bookkeepe			1.	umbin		mpany
To E	,	ashingto	n Fox				18. Mother's N Mary	Gertru			e)	
	19a. Informant's Na	me/Relationship (7	ype, Print)			ng Address (Street				y or Town, \$	State, Zip	Code)
	Susan Fr	ey/daught	ter			Box 2888	German	Date		c. Location	- City or T	own. State
		Cremation 3 5	Removal from State			natory or other pla	ce)	Duto				
	21. Signan e of Eur	neral Service Licen	Wir	ector		Hame and Address Baltimore	•	ard 655	W.	Balti	more	Street
	23a. Part L. Enter the shock, or hear Immediate Cause (disease or condition resulting in death)	t failure. List only o Final	plications that caused one cause on each line a. Due to (or	the death. Do i		er the mode of dyi			y arrest,			Approximate Interval Between Onset and Death
lical Examiner	Sequentially list con cause. Enter Under Cause (Disease or i that initiated events resulting in death) L	lying linjury	С	a consequence								
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 9 Unknown	nonths?	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal deat		Ectopic pregnan Other (specify)	су		_	1	ate of deliverate	very Day Year
ed by Ph	Part II. Other signif	tant conditions of	ontributing to death b	ut not resulting	in the ι	ınderlying cause g	ven in Part I.		id tobace	co use cont		the cause of death?
Complet	Dyn	te o so	951					р	vas an utopsy erformed	1?_	prior to co death?	opsy findings available ompletion of cause of
Be	25. Was case referre examiner? 1 Yes 2	ed to medical	Hospital:			lott	lace of Death (Ch					
te: To	27. Manner of Death) _	1 ∐ Inpati 28a. Date of inju (Month, Da		utpatier Time of Injury	nt 3 🗆 DOA	4 X Nursing y at	Home 5 P				(y)
Medical Certificate:	Natural 2 Accident 3 Suicide 4 Homicide	5 Pending Investigation 6 Could not be determined	28e. Place of Inju	ury - At home, fa			Yes 2 No	28f. Locatio	on (Street	t and Numb	per or Rura	al Route Number,
al Ce			building, etc						Town, St			
Medic	(Check 2 only one 3	Medical Exam Certifying Nur	sician: To the best of iner: On the basis of e se Practioner: To the	xamination and/	or inves	tigation, in my opin	on, death occurre	d at the time, da	ate and pl	lace, and du	ue to the ca	ause(s) and manner stated.
	29b. Signature and t	title of certifier MAA	20/1	<u> </u>	41	29c. Licens D1642			29d.	Date signe	Month,	Day, Year)
			D., 7404 V				ick, MD		'		')	
e Ir	31. Date filed (Moot	7 1 8 2011	32. Registra	ar's Signature	ar	W	40.00					

Stat Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 6:45 A M Physician/ Nonth ber 2011 George Anderson Foote Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Keswick Baltimore N/A 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Min 718-09-9456 **Director** 1 🗓 M 2 🗆 F 90 May 16, 1921 Virginia Usual Residence of Deceden ems 23a or 28a-f show r must be notified at 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland Director 1 Yes 2 No MD. Baltimore Timonium 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 237 Deer Fox Lane 21093 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Examiner Armed Forces?

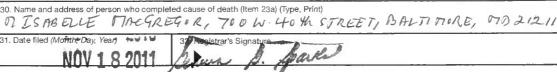
1 X Yes 2 No Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or any injury or other traumatic event. the Martical Examination þ 1 X Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🙀 No Specify: Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) History Professor College Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Mattie Hunter Gaston Foote 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>237 Deer Fox Lane Timonium,</u> MD. C. Lynn Featherston/ Friend altimore, 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗆 Burial 2 🔀 Cremation 3 🗆 Removal from State Hilltop Service Co. 4 ☐ Donation 5 ☐ Other (Specify) 11-17-11 Towson, MD. 21. Signature M uneral Service Licer ^{22. Name and} Ruck of Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final n sician/ End-stage dementia disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicis. Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year signed by the at Id be detached for Part IJ. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ arternscleratic heart disease Hypertens ive 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No Coronary disease 24a, Was an cate has page 2 s Yes 2 No Division of Vital 25. Was case referred to medical completely filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Hospital 1 Tes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury 5 Pending 1 Natural Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

31. Date filed (Month, Day, Year) NOV 1

> or babelle Tax



State Registrar D13657

November 15,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36882 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Pate of Death Physician/ Forsythe syemper Paul 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Baltimore Washington Medical Center Glen Burnie If Under 1 Year I If Under 24 Hrs. Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 1 🛛 M 2 🗆 F 10/20/1943 Mary land **Director** 214-40-0511 48 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 416 Padfield Boulevard 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or 1 Never Married 2 Married ģ 1 X Yes 2 ☐ No If Yes, Give 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-003 3

Widowed 4 □ Divorced Specify. Completed Year or Dates White permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Chemicals Shipping Specialist Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Griffin Forsythe Isabelle Garner Harry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Padfield Boulevard, Glen Burnie, MD 21061 Candy Fontz / POA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 11/15/2011 Hanover, Maryland 4 X Donation 5 ☐ Other (Specify) Anatomy Gifts Registry Signature of Mineral Service Licensee 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death)) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury sician and burial-transit Exami The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year the 9 🗌 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed been si 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 has autopsy perforn death? certificate 1 🗌 Yes 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 1 Tes ည 1X Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural 2 Accident 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 1 Tes 2 No Investigation Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier

State Registrar address of person who completed cause of death (Item 23a) (Type, Print)

32. Regist/ar's

ed (Month, Day, Year,

NOV 1 8 2011

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Anthony Andrew Grelli Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Baltimor FRANKLIN Square Hospita Rosedal Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth **Funeral** 1 XM 2 □ Hours Min. (Month, Day, Year) 92 Director 216-03-0622 Usual Residence of Decedent 28a-f shov 10b. County aţ 10a. State 10c. City, Town or Location Director permit. Page 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f si any injury or other traumatic event, the Medical Examiner must be notified. Md. Balto. Nottingham 10f. Zip Code 10e. Street and Number Funeral 3909 Pinedale Drive 21236 ANTHONY Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto F 12. Was Decedent Ever in U.S rmed Forces?

X Yes 2 No þ 1 Never Married 2 X Married 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 3 🗌 Widowed 4 🗌 Divorced Completed 1942-1945 Decedent's Usual Occupation (Give kind of work done during most of workin life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Car Sales 10th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name မ Alexandro Grelli Catheri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Evelyn Grelli Spouse 3909 Pinedale Drive 20a. Method of Disposition 20b. Place of Disposition (Name of 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Moreland 11 - 1922. Name and Address of Facility Sch 21. Signature of Funeral Service Licenses 9705 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ e to (or s a consequence o disease or condition Medical resulting in death) Examiner Gastrointe Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury that initiated events resulting in death) Last physician and s the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the as ding IF FEMALE: use 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) atten for u Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à HyperKalemia Completed STAGE Renal failure End cate has I certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check Be examiner? Hospital: Other: 4 Nursing Ho 2 No 1 🗌 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA

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Birthplace (State or Foreign Country)

2011

Registrar DHMH 17 Rev 7/2009

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State

27. Manner of Death

1 Natural

2 Accident
3 Suicide
4 Homicide

29a. Certifier

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only one

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NOV

29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

5 Pending

Investigation 6 Could not be

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate:

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Germani, Louis

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			for State of N State of N Registrar	/laryland		artment of F rtificate of L		nd Mental Hy	giene Reg. No. 20		36884
i	Physicia		Decedent's Name (First, Middle, Last) Louis Joseph Germani					2. Date of De Month	ath Day	Year	3. Time of Death 4.15 AM
	Medic Examin Funeral			Age (In yrs. la	ter ast birthday)	4b. City, Town, or Rose (If Under 1 Year Months Days	If Under 2	1 Hrs	4c. County Bal	9. Birth	MORP
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036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once.	Completed by Fune	11. Marital Status 1 □ Never Married 2 ☒ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Armed Forces' 1 ☒ Yes 2 □ If Yes, Give Year or Dates.	? □ No WW []			n, Mexican,	n? (Specify Yes or No- Puerto Rican, etc.)	14. Rac	e - Americ ck, White, White	can Indian, etc.
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, Maryland	d 2 should alth and Me 27 is marl er traumati		19a. Informant's Name/Relationship (Type, Print) Theresa.M. Germani/Wife		19b. Mail 6018	ing Address (Street Mannington	and Number Avenue	or Rural Route Numbe Baltimore N	er, City or Town, S MD 21206	state, Zip	Code)
Baltimore,	Page 1 and nent of Heal ant If item ary or other		20a. Method of Disposition 1 Removal from Stat 4 Donation 5 Other (Specify)	+c C	emetery, cre	osition (Name of ematory or other place ort of Jesus	ce)	Date 11/17/11	20c. Location Dundalk	•	
Balt	permit. Page Department o Important. If any injury or once.		21. Signature of Funeral Service Licensee		2	2. Name and Addre Leonard J. 5305 Harfor	Ruck, I	nc. Baltimore M	arvland 2	1214	
المراجعة المراجعة	Ph_sician/		23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each li		h. Do not en						Approximate Interval Between Onset and Death
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. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medica	IF FEMALE: 23c. If yes, outcome 1	h 2 ☐ Feta tat time of d	al death 3	☐ Ectopic pregnan: ☐ Other (specify) _	су			ate of deliverate	very Day Year
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	To the within the complete com	-	29b. Signature and title of certifier	10	578 EL	29c. Licens		21	29d. Date signe		
1	XIV		30. Name and address of person who completed cause of DR. LAURA STEELE	f death (Item	23a) (Type,	Print)	Sauar	Re Drive	Balti	mar	e MD 21237
	Stat Registra		31. Date filed (Month, Day, Year) 32. R 33. R 34. R 35	trar's Signat	ture	barker	5				
				4	- 1/						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar 36885 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 11 Month 14^{Day} Physician/ 2011 8:28 AM Elizabeth C. Grabarek Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford Bel Air Upper Chesapeake Medical Center If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 220-14-5994 1 □ M 2 🏋 F 88 **Director** 10/01/1923 Ohio Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Harford 1X Yes 2 No Maryland Bel Air 10e. Street and Numbe 10f. Zip Code ō 10g. Citizen of What Country? ms 23a or must be r 21014 Funeral 128 W. Ring Factory Rd. Apt. 1312 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or ite Black, White, etc. Completed by 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 XNo Specify: 3 X Widowed 4 Divorced 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) r than ". the M Elementary/Secondary (0-12) College (1-4 or 5+) 4 Homemaker At Home 12 other Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) alth and Mental I n 27 is marked o 2 Margaret Staley John Crawford 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
25 Court Dr, Joppa, MD 21085 Ellie Donovan 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot
once. 1 Burial 2 Cremation 3 Removal from State Harford Mem. Gardens 11/18/2011 Aberdeen 4 Donation 5 X Other (SpecifEntombment 22. Name and Address of Facility Tarring—Cargo Funeral Home, P.A. 333 S. Parke St, Aberdeen, MD 21001 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. terval Between Onset and Death Immediate Cause (Final Phylician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: detached for use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No 1 ☐ Yes 2 ☐ 9 ☐ Unknown the 9 Unknown o Part all, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 hknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to make the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, Hospital 2 No ျ 1 Yes 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner o Peath Division of 28a. Date of injury 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 \(\text{Yes} \quad 2 \(\text{D} \text{ Ne} \) (Month, Day, Year) 1 / atural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined building, etc. (Specify) City or Town, State) Medical 1 A critifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) H0062765 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kurtom 500 Upper Chesapeake Dr Bei Air, Mr 31. Date filed (Month, Qay, Year) • State Registrar

DHMH 17 Rev 06-2011

DHMH 17 Rev 7/2009

Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

VOID

CERTIFICATE

2011-36887

SEE

CERTIFICATE #

2011-39011

Deceder 14's Name- Narvel Harvey

DOD - November 12,2011

Completed 1/13/12 by Anna Amuki Taylor.

11-08548

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Physici	ian/	Registrar 1. Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death
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Euroral		· · · · · · · · · · · · · · · · · · ·	n yrs. last birth			rs 8 Date of Birth	(MM/DD/YYYY) 9. B	
Funeral Director		219-92-9933 XM 2 F	-		Days Hours Mi		Fore	
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any			c. City, Town		-			10d. Inside City Limits
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens and attural?, or items 23a or 28a-f sho Injoury or other traumatic event, the Medical Examiner must be notified at once.	-	Renee M. Hamrick /wife		1318 Eas	t Spring	meadow	Court Ed	gewood MD
re, s l and f Heal ff iten er tra		20a, Method of Disposition 1 Burial 2 Cremation 3 Removal from State	20b. Place o cremato	f Disposition (Name only or other place)	of cemetery,	Date	20c. Location - City of	
Page:		4 Donation 5 Other Specify:	Bayv	or other place) iew Crem	atory 11	/16/11	Baltimo	re MD
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ox 6 ath cer attendi	sicia	past 12 months? 4 Pregnant at time 1 Yes 2 No 9 Unknown	e of death 5	Other (Specify)				
he des	Phy.	Part II. Other significant conditions contributing to death but	rt not reculting	in the underlying car	rea given in Part I	23e Did tob	acco use contribute to	the cause of death?
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be After this certificate has been signed by the attending physici wheral director, page 2 should be detached for use as the buri	þ	Tarin Other Ognitical Contributing to death but	it not resulting	y in the dilucitying cat	ase giver in rait i.		2 ✓ No 3 Pro	
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Division of ¹ To the Hospital or Attending Pb within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral		4 Homicide determined (Specify) Local 29a, Certifier 1 Certifying Physician: To the best of my kn					ate) ad & Compass Roa	
the Ho nin 24 the Fu	Medical	one) 2 Medical Examiner:On the basis of examina						
To t	Med	and manner stated. 29b. Signature and title of certifier			cense number		29d. Date signed (M	
		Daniel Brendla 11 man		0	.C.M.E.		November 15, 2	2011
		30. Name and address of person who completed cause of death	h (Item 23a)					
©√		Pamela E. Southall, MD Assistant Medical	Examiner	900 W. Baltin	nore Street, Balt	imore, MD 212	223	
	tate	NIIIV 7 S/ 2/1177 1 29	Signature	parker				
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State of Maryland / Department of Health and Mental Hygiene 2 36889 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year : 47 AM Elaine Harris 201 Medical November 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital of Baltimore Sinai Baltimore City 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number . Age (In yrs. last birthday) **Funeral** 1 - M 2X F Hours 219-34-4821 Director 74 12 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 💢 Yes 2 🗆 No Harre MD NA Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 3315 West Rogers Ave 21215 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. , or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. "natural", Completed 3 Widowed 4 NDivorced Specify: Black 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. atholic Elementary/Seconday (0-12) College (1-4 or 5+) Archdiocese 12th grade Superviser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Alice Janet Brown Harold Albert Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21244 Weston Winds Circle, Windsor Mill, Keith Harris-Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State 11/21/2011 Woodlawn, Md Memorial Park King ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Masch F/H West
4300 Wabash Ave, Baltimore, 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Hepatic Failure disease or condition Medical resulting in death) < 8 weeks Examiner malignance Hepatic Sequentially list conditions, Examiner for ea a consequence of cause. Enter Underlying burial-transit Cause (Disease or iinjury that initiated events autoimmune and resulting in death) Last Due to (or as a consequence of) anding physician ause as the burial-Physician/Medical The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown jo Day Month Year detached 1 the ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records, secondary to Gastromtestinel bleed 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 2 No 1 Yes Yes funeral director, 25. Was case referred to medical Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No hours after death, ineral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by th Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certification 29d. Date signed (Month, Day, Year) 29c. License number November 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRIVANKA IYER 0.5 MBBS Sinai 32. Registrar's Signature State NOV 1 8 201 Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36890 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 815 PM George Louis Iserman 2011 11 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Rosedale FRANKLIN SQUADE HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 16, 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 X M 2 □ F Months Hours Min Minnesota Director 218-42-9908 65 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examiner must be notified at 14 Yes 2 No Director Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21221 14 Eugene St. Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No 1963- Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 Specify: white 1 ☐ Yes 2 🗓 No If Yes, Give Year or Dates: Specify. δ 1966 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) United Parcel Service 12 truck driver 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hazel Carroll Ronald Louis Iserman ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Eugene Ave; Baltimore, MD 21221 19a. Informant's Name/Relationship (Type. Print) Diane Iserman - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ser Rona 22. Name and Address of Facility State Anatomy Board 655 W. Balitmore St; Baltimore, MD 21201 23a. Pa 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate use (Final disease or con resulting in death) **Physician** a. Squamous Cell ue to (or as a consequence of): carcinoma /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 □Yes 2 □ No 9 Unknown 9 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed this certificate 1 □Yes 2 ☑No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? æ 26. Place of Death (Check only one) 1 Yes 2 100 Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RESODOO 13-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DR Baltomd 21237 David 32 Registrar's Signature State Green Registrar

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Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Hygiene Certificate of Death

Reg. No. 1 - For State Registrar I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBE Physician/ IEFFERS 30 2011 Medical County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** ALTIMORE HOSPITAL RANDAIISTOW ORTHWEST 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under Year If Under 24 Hrs. 8. Date of Birth **Funeral** 1 M 2 D F Months Min. Director 28a-f show 10b. Count City, Town or Location 10d. Inside City Limits Director ms 23a or 28a-f s must be notified 1 Yes 2 No 10g. Citizen of What Country? 10e Street and Number Funeral USA items 2 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Examiner Yes, specify Cubar Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates ed other than "natural", event, the Medical Exar Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working outh and Mental Hygiene.

27 is marked other than "r traumatic event, the Med e. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Be 17. Father's Name (First, Middle, Last) ည 1 and 2 should b me t's Name/Relationship (Type er, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Important: If item 27 any injury or other tra ndsor Baltimore, 20b. Place of Disposition (Name of ceptetery, cremator) of other place d of Disposition 20c. Location -j 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) preral Services re of Francial Service Lig m) 21/33 righer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. shock Immediate Cause (Final SE Ph_sician/ SHOCK PTIC disease or condition Medical resulting in death) Examiner OSTRIDIU WEEK Sequentially list conditions, ir any, reading to immediate cause. Enter Underlying Examiner DAVIS Cause (Disease or iinjury that initiated events resulting in death) Last RINARY and burial-trar Due to (or as a consequence of) attending physician Physician/Medical that the death certificate be 68760 the page 2 should be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav Pregnant at time of death the 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? OWER 24a Was an autopsy performed? Yes 24 has certificate 1 Yes 2 No or Attending Physician: 25. Was case referred to per dica completed filled in by the funeral director, 26. Place of Death (Check only one) Certificate: To Be examiner? Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident within 24 hours after deal To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Centrying Numer Practioners To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D66166 a 20 30 2011 OCTOBER 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MUDUSAR KRAM KAZA

State Registrar 31. Date filed (Month, Day, Year,

NOV 1

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3

22. Registrar's Signature

3. Time of Death 0613 hrs **Baltimore County** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director 46 Yrs. Country) 104/1965 217-94-0200 1 M 2 F Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County MD BAUTIMORE 1 Yes 2 No with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2018 WILHELM AVENUE USA 21237 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White etc. Armed Forces? 1 Never Married 2 Married 1X Yes 2 BLACK Pages 1 and 2 should be filed within 72 hours after thent of Health and Mental Hygiene.
 Tant! If item 27 is marked other than "natural", o por other tranmatic event, the Medical Examiner in por other tranmatic event, the Medical Examiner in 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: 百 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) SCHMIDTS BAKERY Baltimore, MD 21215-0036 YRODUCTION WORKER 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) LEROY EDWARD JOHNSON, SR. DELORES 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AVE. BALTO, MD. 21237 ANGELA D. JOHNSON WIFE) 2018 WILHELM 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 11/23/2011 BONDERS TORES T 1 Burial 2 Cremation 3 Removal from State BALTIMORE, MD 4 Donation 5 Other Specify: 22. Name and Address of Facility GREENE FUNERAL SEVS AUGHN 21. Signature of Funeral Service Licensee ORK MD. 21212 KOAD. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval **Physician** Between Onset and (Madical Death a. Multiple Injuries Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical attending physician a for use as the burial -UNPENDED AMENDED #20b, perFH, G921, 11/28/2011, WS Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Fetal death Live birth 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed death? page Yes 2 No 1 Yes the Hospital or Attending Physician: hin 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) director, Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Nursing Home 5 Residence 6 🗸 Other: Scene this 1 Yes 2 No funeral 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After Certification: Driver of vehicle which struck a fixed object and Nov 15. 2011 0600 hrs 1 Natural 1 Yes 2 ✔ No Pending the Director: was ejected 2 🗸 Accident Investigation filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) Ramp from I-695 to I-795, Pikesville, MD within 24 hours a To the Funeral I determined 4 Homicide (Specify) Interstate/Express 29a, Certifier (Check only completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 15, 2011 30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223

State Registrar

OCME

32. Registrar's Signature

ORIG!NAL

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homas Jefferson		State of Maryland / Department of Health and Mental Hy 1- For State Certificate of Death		201	1 3689
		Registrar	Reg 2. Date of Death	j. No.	3. Time of Death
Physician Medical Examina	-		Month November	Day Year 16, 2011	2305 hrs
1		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Death	
		St. Agnes Hospital Baltimore			
Funeral	٦	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.	1	(MM/DD/YYYY) 9. Bir	in
Director	k	218-22-8771 12M 2 F 83 Yrs. Mollius Bays 110013 Milli	06/20	11928 00	untry) MD
	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
w any					1 Yes 2 No
Maryland 28a-f show d at once.	힑	10e. Street and Number 10f. Zip Code	100	g. Citizen of What Cou	ntry?
72 hours after death with the Maryland na "natural", or items 23a or 28s-f she all Examiner must be notified at once	Director	753 N. Grantley Street 21229		USA	
ith th		1100		14. Race - Amer	ican Indian, Black,
item	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto F	Rican, etc.)	White, etc.	
E . E	g E	Widowed 4 Divorced in res, sive real		Specify: D 4	ick
ours a			ork done ed)	16b. Kind of Business/	States
36 thin 72 h than "r than "r	틹	Elementary/Second (0-12) College (1-4 or 5+)		Dast 1 C	Sorvico
5-003(Jiled within Hygiene. d other that, the Media	Completed	17. Father's Name (First, Middle Last)	(First, Middle, M	aiden Sername)	1
	Bec		hoth	MCGi	11
2121! hould be fill and Mental Fis marked			usal Route Numb	per, City or Town, State	
		Leuna Watties-Phillips 7435 Nathydale k	ed, 41	Resville, Y	MD 21208
ore, MCs l and 2 s of Health at If item 27		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date '	20c. Location - City or	Town, State
Pages lent of unit: J	U.	4 Donation 5 Other Specify: Survison to rest 11-	29-11	Wings	MITIS, MUD
Baltimore permit. Pages 1 a Department of H Important: If it	1	21. Ignature of Funeral Service Licensee 22. Name and Address of Pacility	ene F	uneral S	envices
	_	23a. Part I. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arre	st shock or heart	Approximate Interval
Physician		failure. List only one cause on each line.	,	,	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Complications of Cholecystectomy Due to (or as a consequence of):			
		Sequentially list conditions, b			
	亨	if any, leading to immediate Due to (or as a consequence of):			
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
ox 68760, ath certificate be executed attending physician and or use as the burial - transit	٩	d	12		
oe exe ician a	dical	☐ AMENDED ☐ AMENDED 23a, pt. II, 27, per me, g923 1-18-1	12 SM		
760 icate icate g bhys	S S	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnan	incv	23d. Date of deliver Month	y Day Year
c 68	cia	past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnant 3 Ectopic pregnant 4 Pregnant at time of death 5 Other (Specify)		1	
BOY e death the attr	Physician/Medi	1 Yes 2 No 9 Unknown 9 Unknown	1 a 2 2 1 1 1		the second death?
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F Vir	ပ္	1 V Yes 2 No impatient 2 P ENOutpatient 3 Don 4 North North		now injury occurred	
n of Iding Pl h.: After e funera	ion:	27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 X Natural 5 Pending			
isio Atter or deat rector by th	icat	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.			ural Route Number, City
Div	Certification:	3 Suicide 6 Could not be determined (Specify)	or Town, S	tate)	
Hospi 24 hou Funci			I due to the caus	e(s) and manner as sta	ated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated	at the time, date a		
F × F ō	ž			29d. Date signed (M November 17, 2	
		Character O.C.M.E.		INOVERNIBER 17, 2	
z l		30. Name and address of person who completed cause of death (frem 23st) Zabiullah Ali, M.D. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore,	MD 21223		
Sta	ate				
Sta Regist		N//// 1 9/7011 /2			

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State of Manyland / Department of Health and Mental Hygiens 201

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ealth and Mental Hygiene	2011	36894

			For State	State of Ma	arylan		ertificate of L			-		-	ı	30027
			Registrar 1. Decedent's Name (First, Middle	, Last)			rtinoato or E	Journ	2	. Date of Dea			3	. Time of Death
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6	Examin		4a. Facility Name (if not institution,	-	17	1-2	4b. City, Town, o					c. County of Dea		
	Funeral		The Hebrew Hom 5. Social Security Number	6. Sex 7. Age		ningt ast birthday)		kvil. I If Unde		Date of Birt		Montgom		e (State or Foreign
	Director		185-24-9115 Usual Residence of Decedent	4 X M 2 🗆 🗆 🗆	0	Yrs.	Months Days	Hours		(Month, Da ept. I	Year)	1931 Pe	ountry) nnsy	lvania
	and show lat	or	10a. State 10b. County		10c. City	y, Town or L	ocation				-		10d.	Inside City Limits
	Maryli 28a-f otifiec	irec	Maryland Montg	omery	Ro	ckvi1	le							1 🗌 Yes 2 🔯 No
	th the 3a or the n	al D	10e. Street and Number				10f. Zip Code					Citizen of What C	ountry?	
	ems 2	Funeral Director	5440 Marinelli 11. Marital Status	12. Was Decedent E	ver in U.S	S. 13.	20852 Was Decedent of H	ispanic O	rigin? (Specify	Yes or No-	υ.	S.A.	erican I	ndian,
036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 ☐ Never Married 2 🛛 Marria 3 ☐ Widowed 4 ☐ Divorced	ied Armed Forces? 1 Yes 2 X	No		If Yes, specify Cuba 1 ☐ Yes 2X No			an, etc.)		Black, Whi	ite, etc. Wh it	e
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ylaı	uld be Menta narked natic e	욘	Benjamin Kanne						lvia Go					
Maryland	d 2 shoualth and 27 is n		19a. Informant's Name/Relations! Annette Kanner				ling Address (Street Marinell							
Baltimore,	e 1 and f of Heg if item or othe		20a. Method of Disposition 1 X By Ial 2 Cremation	3 Removal from State	20b. P	lace of Disp emetery, cre	position (Name of ematory or other place	ce)	Date			Location - City of		
<u>ti</u>	it. Pag urtment ortant: njury o		4 ☐ Donation 5 ☐ Other (S	pecify	Mt.		i Mem. Pa					Angele	s, (CA
Ba	permit Depar Impor any in		21. Signature of Fulleral Service L	Mune			22. Name and Addre Metropoli 5517 Vine	tan St.	Funeral , Alexa	l Serv andria	ice , V	A 22310		
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¥60	sit s	mine	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequ	uence of):								
ER	sate be executed physician and the burial-transit	edical Examiner	that initiated events resulting in death) Last	c. Due to (or as a	consequ	uence of):							\vdash	
18 y	cate be on physicials the bur	dica		d	_								┝	
WNER 68760			IF FEMALE:	23c. If yes, outcome of	of pregna	ncv						001 D-1	- 12	
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Division of Vital Records,	he law re ate has be bage 2 sh	Completed					Age of the second secon			24a. Was autoj perfo 1 \(\sum \) Yes		prior to death?	compl	findings available etion of cause of
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Ţ	Physion this carral direction	일	1 ☐ Yes 2 No 27. Marrher of Death	1 Inpatie	у	ER/Outpati 28b. Time	ent 3 ⊔ DOA	4/				6 Other (Spe	ecify)	
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Division	al or Atte s after de l Directo d in by th	Certificate:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ				treet, factory, office		28	f. Location (S City or Tov		nd Number or Fi te)	ural Ro	ute Number,
	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completed filled in by the funeral director, page 2 should be detached for use as	Medical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of ex Nurse Practioner: To the l	amination	n and/or inve	estigation, in my opini	on, death	occurred at the	e time, date a	ınd plac	ce, and due to the	e cause(
	Vithii To th	-	29b. Signature and title of certifier				29c. Licens	e number	0 04	11	29d. D	ate signed (Mor	ith, Day,	Year)
			Dun	Jamour			1)0	0/0	108	7	M) NCONB	ER	15,2011
	10		30. Name and address of person	PATEL,	us.	.612	Print) WX7	20.	E RJ	De Ro	CK	VILLE!	49-	20852
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			101	State of Marylan	d / Depa	artment of H	lealth and	Mental Hyg	giene					
		-	State Registrar	tificate of <i>E</i>	Death		Reg. No. 20		36895					
	Physicia	n/	Decedent's Name (First, Middle, Last)		2. Date of D Month			/ear	3. Time of Death					
	Medic	cal	Erotoula	<u>Karantzal</u>	is	1		Nov.	17 201		5:22 A ^M			
	Examin	er	4a. Facility Name (if not institution, give stre	4b. City, Town, or		th	4c. County of Baltim							
	Funeral		The Maples 5. Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday)	Towson If Under 1 Year	If Under 24 Hrs		h	9. Birthp	lace (State or Foreign			
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	d wow t	_	Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo	cation		Dec. 20	1919	Gree	Od. Inside City Limits			
	arylan a-f sh fied a	Director				cation				'	1 Yes 2 No			
	he Ma or 28		Maryland Baltimore 10e. Street and Number	Tows	son	10f. Zip Code			10q. Citizen of Wh	nat Count				
	with the 23a sales to sat be	eral	1 Southerly Court U	Init 406		21285			U.S.A.					
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho ledical Examiner must be notified at	Funeral		. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of Hi f Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-	14. Race -					
36	ifter d ", or i amin	þ	1 Never Married 2 Married	1 Yes 2 No If Yes, Give	1	r ves, specify Cuba I ☐ Yes 2 🙀 No		to Rican, etc.)	0	White, e				
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	1 and 2 s of Health item 27 i		William Karantzalis 20a. Method of Disposition		-	<u>larfield</u>	Court, I							
Baltimore,	nt of h		1 X Burial 2 Cremation 3 Re	moval from State	emetery, crer	sition (Name of natory or other plac		Date	20c. Location - C					
Iţiu	permit. Page 1: Department of I Important: If it any injury or of		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	Gre	ek Cem	etery 2. Name and Addres		21,2011			Maryland			
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г			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	ause on each line.							Approximate Interval Between			
	h sician/		Immediate Cause (Final disease or condition	Congos	true	Heo	1+ t	allen	2	Le	Onset and Death			
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Вох	res that the death certific signed by the attending of d be detached for use as	Physician/M	1 Yes 2 No 9 Unknown	4 ☐ Pregnant at time of cg ☐ Unknown	leath 5 L	Other (specify)			Monti	П	Day fear			
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S, F	signe signe ld be	d b	ATRIAL FI	SRILLATTO	الم			1 🗆 \	res 2 No 3	☐ Prob	ably 4 🗆 Unknown			
To Could be seed a set of the set								24a. Was a	an 24b. Were autopsy findings available					
Sec.	Solution of the cause of the ca													
alF	an: T		25. Was case referred to medical			26. Pla	ace of Death (Che		ZINO II	_ res	ZINO			
Vit	nysici lis cel	To E	examiner? 1 Yes 2 No	pital: 1 lnpatient 2	ER/Outpatier	nt 3 🗆 DOA Othe	er: 4 Nursing	Home 5 Resid	ence 6 Other	(Specify)				
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ion	ttendideath death tor: A	Certificate:	2 ☐ Accident Investigation 3 ☐ Suicide 6 ☐ Could not be				Yes 2 ☐ No							
ivis	al or Attending P s after death. I Director: After t d in by the funera	Cer	4 Homicide determined	me, farm, str	eet, factory, office	28f, Location (S City or Town	(Street and Number or Rural Route Number, own, State)							
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 424 hours after death. To the Funeral Director, After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Medical		n: To the best of my knowl										
	the H hin 24 the F mplete	Me	only one) 3 Certifying Nurse P			death occurred at t	he time, date and	place, and due to th	e, date and place, and due to the cause(s) and manner stated due to the cause(s) and manner as stated.					
	5 ₩ 6		29b. Signature and title of certifier	7	0	29c. License		1	29d. Date signed (-				
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	Sta		31. Date filed (Month, Day, Year)	32. Figiatrar's Signat			,	Exer						
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DHMH 17 Rev 06-201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 36896 Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 5 2011 Physician/ Irma Kronenberg 3:23 P M November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTH OAKS HEALTH CENTER PIKESVILLE BALTIMORE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Director 061-03-9602 1 🗆 M 2 🗓 F 101 08/14/1910 PA Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10a State 10h County 10d. Inside City Limits 10c. City, Town or Location Director 1 🗆 Yes 2 🗓 No BALTIMORE PIKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be Funeral 725 MT WILSON LANE 21208 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 X Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Divorced 4 Divorced WHITE Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) CLERICAL FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 KRONENBERG SAMELSON BERT **JEWEL** 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, MARK COLVIN / NEPHEW 4326 ROLAND SPRINGS DRIVE, BALTIMORE, MD 21210 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date permit. Page 1 a
Department of F
Important: If ite
any injury or ott
once. 1 X Bunal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11/17/2011 BALTIMORE, MD OHEB SHALOM CONG. 21. Signature 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition End-Stage Dementia Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last ending physician and use as the burial-trans Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 g Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 🗌 Yes 2 Mo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 this certificate 1 Yes 2 No the Hospital or Attending Physician: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending Natural 2 🗌 No 1 Yes Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MSRay apalnem.D D0057465 115/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore \$V MO N.S Rejapakse, M.D 21209 28355min N 5203

DHMH 17 Rev 06-2011

State

Registrar

31. Date filed (Month, Day, Year) **NOV 1** 8 2011

Box 68760

P.0.

32 Registrar's Signature

was

			For State of Mary				Mental Hy	giene	
	_		Registrar 1. Decedent's Name (First, Middle, Last)	Cer	tificate of D	<i>Death</i>	2. Date of Dea	Reg. No. 2	3689 / 3. Time of Death
	Physicia Medic		Yongzhen Liu				Novembe		011 8:00 pM
	Examin	er	4a. Facility Name (if not institution, give street and number) Collingswood Nursing & Rehab	.	4b. City, Town, or Rockvill	Location of Death		4c. County of Montgo	
	Funeral Director			yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth		Birthplace (State or Foreign Country) China
	A	'n	Usual Residence of Decedent	c. City, Town or Loc	cation				10d. Inside City Limits
	Marylar 28a f sl otified	irecto		Rockville			_		1 ☐ Yes 2 🔀 No
	with the 23a or 1st be n	Funeral Director	10e. Street and Number 11406 Potomac Oaks Drive		10f. Zip Code 20850			10g. Citizen of Wha	at Country?
336	s after death al", or items Examiner m	by	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever Armed Forces? 1 Yes 2 X No If Yes, Give Year or Dates.	If	Vas Decedent of His Yes, specify Cubar	n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	Black, \	American Indian, White, etc. Asian
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a -f show aumatic event, the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+	(Give k	ent's Usual Occupa ind of work done d O NOT use retired) SSOT		ing	16b. Kind of Busin	ness Industry
/land 2	d be filed w Mental Hygi arked other itic event, t	To Be (17. Father's Name (First, Middle, Last) Yianong Liu			18. Mother's Nam		Maiden Surname)	
, Mary	e 1 and 2 should be file of Health and Mental I f item 27 is marked o r other traumatic eve		19a. Informant's Name/Relationship (Type, Print) Ming A. Yu, daugter					; City or Town, State 11e,MD 2	
Baltimore,	permit. Page 1 ar Department of He Important: If iter any injury or oth once.		1 Durial 2 Cramation 2 Demousl from State	Chesapeak	natory or other place ie Cremato	ory 11/1	Date .7/2011	20c. Location - Cit Beltsvil	le, MD
Balt	permit. Depart Import any inj		21. Signature Figure Licensea Mi					al & Crem ng, MD 20	ation Svcs. 1910
1	Physician/		23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	death. Do not enter		g, such as cardiac	or respiratory arm	est,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death) Due to (or as a co End St	nsequence of): age Renal	Disease				
-	uted nd ransit	Examiner	Sequentially list conditions, b. cause. Enter Underlying Cause (Disease or linjury that initiated events c.	ovascular	Accident	t			
00	icate be executed physician and is the burial-transit	edical E	resulting in death) Last Due to (or as a co	nsequence of):					
20x 68/	death certif he attending ed for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼No 9 ☐ Unknown 23c. If yes, outcome of p 1 ☐ Live Birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3 🔲	Ectopic pregnancy Other (specify)	у		23d. Date o	
, r.	es that th signed by I be detac	by	Part II. Other significant conditions contributing to death but no	ot resulting in the ur	nderlying cause giv	en in Part I.	23e. Did to		te to the cause of death?
Vital Records,	The law requires that the ate has been signed by to page 2 should be detach	Completed					24a. Was a	an 24b. Wer	re autopsy findings available or to completion of cause of
ž E	an: The tificate or, pag		25. Was case referred to medical		26. Pla	ace of Death (Chec	1 🗆 Yes		Yes 2 No
<u> </u>	hysicik nis cer I direct	To B		2 ER/Outpatient	t 3 🗆 DOA Othe	r: 4【 Nursing H	ome 5 🗌 Resid	ence 6 Other (S	Specify)
on or	Attending Physician: The law er death. ector: After this certificate has by the funeral director, page 2 by	Certificate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation 28a. Date of injury (Month, Day, Ye	ar) 28b. Time of injury	28c, Injury work? M 1 🗆		28d. Describe h	ow injury occurred	
DIVISION OF	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completed filled in by the funeral director,		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - building, etc. (Sp.	At home, farm, stre secify)	et, factory, office		28f. Location (S City or Tow.		r Rural Route Number,
	he Hosp in 24 hou he Funer pleted fil	Medical	29a. Certifier (Check only one) 1	ination and/or investi	igation, in my opinio	n, death occurred a	t the time, date ar	nd place, and due to	the cause(s) and manner stated.
	To the common to		29b. Signature and fitte of certifier		29c. License D3013			29d. Date signed (<i>N</i>	* * * * * * * * * * * * * * * * * * * *
			30. Name and address of person who completed cause of death M. Rita Ghosh MD; 14812 Phys	(Item 23a) (Type, Pr	rint)				
	Stat Registra		31 Date filed (Month Day Year) 32 Registrar's 9						

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36898 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 16, Orville John Lamp 2011 3:50 P. M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A Baltimore City Sinai Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign (Month, Day, 1 XM 2 □ F Months Country) Director 82 217-22-8907 1928 Maryland Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore Baltimore Maryland 1 🔀 Yes 2 🗌 No 10e. Street and Number ò 10f. Zip Code iral", or items 23a or Examiner must be 10g. Citizen of What Country? United States Funeral 21211 1013 W. 38th Street of America 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc þ 1 Never Married 2 X Married Je filed within ental Hygiene. urked other than "natural", or "ent, the Medical Exan Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Steel Worker Armco Steel Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F. ပ John Orville Lamp Avalon Lescalett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1013 W. 38th Street Baltimore, MD 21211 and 2 s Health Mrs. Doris M. Lamp/ wife item 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any Injury or ot Evans Funeral November 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 18, 2011 Chapel- Bel Air . Signature of Fundral Service Licensee 22. Name and Address of Facility
Reaceful Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death CISEASF Immediate Cause (Final CHronic OBSTRUCTIVE pulmonary Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence off or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): ysician a Physician/Medical Box 68760 attending physi IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, CEVEDYAL VASCLLAV ALCUDENT Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an certificate has b irector, page 2 sl autopsy performed? prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 No Other: 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation М 1 Yes 2 No 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month, Day, Year) Om mo Malle D35102 NovemBerl 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) North CHarles Street Bolfmore mary 5901 Don m.D 31. Date filed (Month, Day, Year) State NOV 18 Registrar DHMH 17 Rev 7/2009

ORIGINAL.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36899 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ November 16, 2011 6:59 P M Mandia Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster Dove House If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Days (Month, Day, Year) Director 109-30-5882 1 🕅 M 2 🗆 F Oct 4, 1939 New York 72 Usual Residence of Dece 28a-f show 10d. Inside City Limits artment of Health and Mental Hygiene. ortant; If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2X No Carroll MD Westminster 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 682 Skyline Way 21157 USA within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: White 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) 12 Restaurant Owner Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tessie Miglino William Mandy permit. Page 1 and 2 should be Department of Health and Men Important; If item 27 is marke any injury or other traumatic s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lisa Candela/daughter 682 Skyline Way Westminster, MD 21157 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2X Cremation 3 Removal from State Final Journey Crematory 11/19/11 Woodbine, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 of Funeral Se 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ ordionyopin Medical resulting in death) Due to (or as a consequence of) **Examiner** (O/On Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury and -trans that initiated events resulting in death) Last Due to (or as a consequence of) ng physician a eas the burial-Physician/Medical that the death certificate be Box 68760 attending p IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the a Unknown g Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? has page 2 death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2**X** No 4 \square Nursing Home 5 \square Residence 6 X Other (Specify) hospice မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 1 X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No. hours after death. ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a

To the Funeral I

completely filled Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

8

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

29d. Date signed (Month. Dav. Year)

wesminite

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month 12:50 A.M Orilla J. Murphy Wenn 26 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Glen Burnie Baltimore Washington Medical Center 8. Date of Birth (Month, Day, Year, April 14 Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X F Hours 1929 Yrs ΚY Director 218-22-9818 Usual Residence of Decedent shov ms 23a or 28a-f sho must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 X No Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 114 Cloverhill Road 21122 ral", or items 2 Examiner mus 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. à 1 ☐ Yes 2 ☒ No If Yes, Give 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after White 1 ☐ Yes 2 ☒ No Specify: Specify. "natural", 3 Widowed 4 Divorced Completed Year or Dates or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Cashier Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F ပ Collins Ralph Sizemore Nora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 114 Cloverhill Road, Pasadena, MD 21122 Albert Murphy (spouse) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Department of Important: If it any injury or o once, 1 X Burial 2 Cremation 3 Removal from State Nov 4 Donation 5 Other (Specify) Maryland Veterans Cem! 2011 Crownsville, Maryland 21. Sign, ure of Funeral Se ice 22. Name and Address of Facility Stallings Funeral Home, 3111 Mountain Road, Pasadena, MD 21122 23a. Part 1. Enter the disease, or complicate s the t caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death shock, or heart failure. List only Immediate Cause (Final Physician/ disease or condition resulting in death) ceres Medical r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) sician and burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician should be detached for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy5 Other (specify) Live Birth 2 Fetal death in the past 18 months?
1 Yes 2 No Day Year Month Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s perform 1 Yes 2 No 1 Yes 2 funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) xaminer? 1 Yes Hospital Other: 2 🗆 No ပ Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Funeral Director: After ne11 Natural 5 Pending work MATIENT Jovenber 22011 2 Accident 5:00AM Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined SAdeNA mo HOME Medical

Hospital

State Registra

29a. Certifier

29b. Signature and title of certifier

Dav. Year)

NOV 18

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Daive,

DHMH 17 Rev 7/2009

alon Binsie

Certifying Physician: to the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

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			for State Registrar	or maryland		tificate			and ivid	•	Reg. No	0.0	1 1	36	90
	DI	- /	Decedent's Name (First, Middle, Last)						2	2. Date of De	ath		/	3. Time of	Death
	Physicia Medio		JOHN WESLEY MARTIN						N	Month Novembe	er 0	9, 20	ear 11	6:52	2 a ^M
	Examir	er	4a. Facility Name (if not institution, give street and r	number)		4b. City, To						. County of			
-	Funeral		SHADY CROVE Hospital 5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1		sburg If Under		B. Date of Birt		ontgo		lace (State or	r Foreian
	Director		144-36-3376 Usual Residence of Decedent	F	62 Yrs.	Months	Days	Hours	Min.	(Month, Da 8/4)	/ 194	9 N	Count	k, NJ	
	yland •f sho ed at	cto	10a. State 10b. County	10c. City,	Town or Loc	cation							10	od. Inside Cit	•
	e Mar r 28a notifi	Dire	MD Montgomery 10e. Street and Number	Gait	hersbu	lrg 10f. Zip (`odo				10- 0	tizen of Wh	at Carret		2 LI No
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ed by Funeral Director	11. Marital Status 12. Was De Armed		l If		nt of His y Cubar	spanic Ori	i, Puerto Ri	fy Yes or No-		14. Race -		an Indian, tc.	Helic
5-0	hour "natur dical	plete	15. Decedent's Education (Specify only highest grade complet	ed)	16a. Deced	lent's Usual and of work			t of working	1	16b. k	(ind of Busi	ness/Ind	lustry	
121	hin 72 ne. than '	Completed	Elementary/Secondary (0-12) College	(1-4 or 5+)	life. DO	O NOT use r	etired)	-							
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Maryland	d 2 should alth and M 1 27 is mal er traumat		19a. Informant's Name/Relationship (Type, Print) Deborah A. Martin/Wife	1				nd Numbe	er or Rural F	Route Numbe				ode)	
Baltimore,	Page 1 an nent of He int: If iterr iry or othe		20a. Method of Disposition 1 ☐XBurial 2 ☐ Cremation 3 ☐ Removal fn 4 ☐ Donatiop 5 ☐ Other (Specify)	om State ce	ace of Dispos metery, crem Olive	natory or oth	er place		Da	te // 20.1.11		ocation - C			
Balti	permit. Departr Imports any inji	ij	21. Sign ture of Experial Service Licensee	SON				s of Facilit	y John		Jen			ral Ho	ome
Č	Physician/ Medical Examiner	er	resulting in death) Due Sequentially list conditions, b.	at caused the death each line. Heroscle to (or as a conseque for a cons	rotic ence of):		10.0	1300					1	Approximate Interval Betw Onset and D	ween
09289	ath certificate be executed attending physician and for use as the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events		rellit	15								Yeary	>
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o u	nding Fith. : After e funer	cate		onth, Day, Year)	injury	м	work?	? Yes 2 🗆	l l	d. Describe i		y occurred			
Division of Vital	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	al Certificate:	3 Suicide 6 Could not be	ice of Injury - At hon Ilding, etc. (Specify)	ne, farm, stre	et, factory, o	office		28	If. Location (S City or Tox			or Rural	Route Numb	e <i>r</i> ,
	Hosp 24 hou Funel stely fi	Medical	29a. Certifier 1 XCertifying Physician: To the (Check 2 Medical Examiner: On the	oasis of examination	and/or invest	igation, in my	y opinior	n, death oc	curred at th	ne time, date a	and place	e, and due to	the cau	ise(s) and mar	nner stated
	o the	Σ	only one) 3 L Certifying Nurse Practition 29b. Signature and title of cartifier			29c. l	icense	number			29d. Da	te signed (/	Month, E	Day, Year)	
0	F > F 0		DO 11 MO 91 MIM	ouch W	10				9		N	ovem	ber	9, 20	î/
)	•		30. Name and address of person who completed conficult Evanush, MD 9	ause of death (Item)	23a) (Type, P	rint) enter	~ D	rive	Rock	vill+,	M	ar/10.	nd	20850	
	Stat Registra	te ar	31. Date filed (Month, Day, Year) NOV 1 8 2011	. Registrar's Signatu	Lark	and a									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36902 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Miller Elizabeth Mae Nov. 12 2011 7:50 Α Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore Gilchrist Hospice Center Towson 1 Year If Under 24 Hrs. Social Security Number If Under Birthplace (State or Foreign Country) 8 Date of Birth **Funeral** . Age (In yrs. last birthday) Days (Month, Day, Year) **Director** 216-32-4994 1 M 2 X F 75 March 9,1936 Maryland 28a-f show should be filed within 72 hours after death with the Maryland and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at Director MD Baltimore Dundalk 1 Yes 2 No ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 313 Jeanwood Road 21222 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. ō þ 1 Never Married 2 XMarried Baltimore, Maryland 21215-0036 1 Yes 2X No Specify. Completed Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) id Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4 or 5+) 12 Years Nurse Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Charles E. Myers Elizabeth A. Triggs it. Page 1 and 2 shours of Health and Mr. m 27 is mr. in. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Warren D. Miller (Husband) 313 Jeanwood Court Dundalk, MD 21222 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Dulaney Valley Mem.Gdns. 11/15/2011 Timonium, MD 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failane. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Year Pregnant at time of death Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 🗓 25. Was case referred to medical Be 26. Place of Death (Check only one) Certificate: To I 1 ☐ Yes 2 ☐ Wo Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After templetely filled in by the funer. Natural 5 Pending work 1 Yes 2 No ☐ Accident☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signer (Month, Day, Year) D71040 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QV

DHMH 17 Rev 06-2011

State

Registrar

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NOV 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First Middle, Last) 2. Date of Death Physician/ Month 1:30 AM Ola Gay Myers November 10 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death itizens Nursing Itome Havre de Grace 1tarford 7. Age (In vrs. last birthdav) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye. Dec. 16, **Funeral** Social Security Number 9. Birthplace (State or Foreign 1 🗆 M 2 😾 F Hours North Carolina Director 215-44-1435 64 Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral with 100 McNamee Lane, Apt. 300 21911 USA death v 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Yes 2 No Yes, Give Baltimore, Maryland 21215-0036 1 Tes 2X No Specify: White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 l h and Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) District Manager Retail Sales Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Willie Bart Blevins Maude Jeanette Harris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21911 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health a item 27 i 100 McNamee Lane, Apt. 300, Joseph Myers / Husband Rising Sun, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any Injury or ot 1 🔀 Burial 2 🗆 Cremation 3 🗖 Removal from State Highview Memorial Gdn 11/12/2011 4 Donation 5 Other (Specify) Fallston, Maryland Funeral Arvice Licensus 21. Sign. tur 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the made of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading immediate cause. Enter Underlying Examine Due to for as a consequence of attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 5 Other (specify) Day been signed by the should be detached Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law page 2 s autopsy 1 ☐ Yes 2 🗷 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Hursing Home 5 Residence 6 Other (Specify) 2 X No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending 1 Yes 2 No 24 hours after death Funeral Director; A Investigation Accident 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifier 29d. Date signed Mont 30. Name and address of person who completed course of death (Item 23a) (Type, Print) (Axuss 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36904 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 16, Physician/ Month Margaret Rachel Monk November 2011 7:31 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland (Month, Day, Y 1 □ M 2🛣 F Months Days Hours Min Director 220-24-8671 83 Sep 1928 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2X No Maryland Harford Darlington 10e. Street and Number 10f. Zip Code ò 10g, Citizen of What Country? the Medical Examiner must be Funeral items 23a 4103 Conowingo Road 21034 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black, White, etc. 'natural", or ò 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 8 Homemaker Own Home Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Oliver Norman Little Carrie Helen Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 is any injury or other trau Raymond Monk / Son 4103 Conowingo Road, Darlington, Maryland 21034 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ŏ 1 ☑ Burial 2 ☐ Chemation 3 ☐ Removal cemetery, crematory or other place, Highview Memorial Gdn: 11/19/2011 4 Donation 5 (Specify) Fallston, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final withdi Onset and Death Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to or as a consequence of Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by 1 ✓ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Ś lation with rapid ventricular rate 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? smoker 2 1 No Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 - ER/Outpatient 3 - DOA 4 Nursing Home 5 Residence 6 Other (Specify) of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be within 24 hours after deat To the Funeral Director: Suicide 3 ☐ Sulcide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 30. Name and address of person who completed ause of death (Item 23a) (Type, Print) 2100 te filled (Month, Day, Year)
NOV 18 2011 State Registrar

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John McLaughlin, Jr.	State of Maryland / Department of Health and Mental Hygiene		0011	0 6 0 0
1- For State Registrar	Certificate of Death	Reg. No.	2011	3690

n Mc∟aughli	, 0	State of Maryland / Department of State 1-For State Registrar Certificate of Maryland / Department of State o		3690
Physici dical Exam		1. Decedent's Name (First, Middle, Last) John T. McLaughlin Jr.	Month Day Year	e of Death 15 hrs
o Ciny		Facility Name (if not institution, give street and number) South Taylor Avenue	4b. City, Town, or Location of Death 4c. County of Death Essex Baltimore County	
Funeral Director		5. Social Security Number 222-62-0518 6. Sex 1 7. Age (In yrs. last birthday) 3 7 Y	If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace Foreign	(State or
w any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Local County		nside City Limits
ryland a-f show	cto	MD Baltimore Esse	2X 10g, Citizen of What Country?	Yes 2 X No
the Mai a or 28	Director	211 South Taylor Avenue	21221 USA	
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygienie. Important: If item 77 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		ras Decedent of Hispanic Origin? (Specify Yes or No-Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indi White, etc.	ian, Black,
ours afte ntural" camine	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Decede	int's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry	
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1 27 3-0036 I be filed within 7 ental Hygiene. rrked other than vent, the Medica	Be	17. Father's Name (First, Middle, Last) John T. McLaughlin Sr.	18.Mother's Name (First, Middle, Maiden Surname) Barbara J. Cornelius	S
MIU ZI d 2 should Ith and Me n 27 is ma numatic ev	ဥ		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Co South Taylor Avenue Baltimore M	•
Dallimore, Noemit. Pages I and Department of Health Important: If item injury or other trau		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Bavview	sition (Name of cemetery, Date 20c. Location - City or Town, S	State
Dermit. P Departme Importar injury or		4 Donation 5 Other Specify:	Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex	. MD
hysician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac or respiratory arrest, shock, or heart Appro	oximate Interval
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death) a. Tramadol Intoxication Due to (or as a consequence of):	n	Death
	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause		_
cuted ind transit	l Examiner	events resulting in death) Last Due to (or as a consequence of): d.		
te be executed hysician and burial - transit	ledical		8a-f,per me,g922 12-5-11 sm	
ath certifica attending ph	2	past 12 months?	etal death 3 Ectopic pregnancy 23d. Date of delivery Month Day ther (Specify)	Year
the		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause	se of death?
S .50 5	ed by	Hypertensive Atherosclerotic Cardiov		
of Vital Recolds, Bysician: The law requir After this certificate has been s meral director, page 2 should I	Completed		24a. Was an autopsy performed? 1 ✓ Yes 2 No 1 ✓ Yes	
ician: The s certificate rector, page	å	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatier	26.Place of Death (Check only one) t 3 □ DOA Other 1 □ Nursing Home 5 □ Residence 6 ✔ Other: Scene	
ling Physic	일	27. Manner of Death 28a. Date of Injury (Month Day Year) (Month Day Year)		
tal or Attending after death. al Director: A led in by the fu	catio	Pending Fd 11-15-11 Fd 4:1		
To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street (Specify) residence	et, factory, office building, etc. 28f. Location (Street and Number or Rural Rout or Town, State) 211 South Tay	ylor Ave
To the Ho within 24 To the Fu completely	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation	rred at the time, date and place, and due to the cause(s) and manner as stated. Ition, in my opinion, death occurred at the time, date and place, and due to the cause	e(s)
F & F S	≅	and manner stated. 29b. Signature and title of certifier	29c. License number 29d. Date signed (Month, Day	(,Year)
		30. Name and address of person who completed cause of death (Item 23a)	O.C.M.E. November 16, 2011	
Ø		Melissa Brassell, MD Assistant Medical Examiner 900 V	V. Baltimore Street, Baltimore, MD 21223	
St	ate trar	31. Date filed (Month, Per Year) 8 2011 32. Redistrar's Signature	allel	

DHMH 17 Rev 1/2001 OCME 2006

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			For State Registrar	State of Ma	-	partmer ertificat			and M		Reg. No.	201	1 36900
	Physici /Medie			men						2. Date of De Month	per 1	Year 201	1121 PM
	Examir		4a. Facility Name (If not institution, giv Johns Hopkins Bayvi	,	enter		Town, or more	Location of	of Death		4c. C	ounty of De	ath
	Funeral Director		5. Social Security Number 6. 5		e (In yrs. last birthd 64 Yrs	ay) If Unde	r 1 Year Days	If Under Hours	Min.	8. Date of Bir (Month, Da July 2.	ıy, Year)		irthplace (State or Foreign country) nada
	rryland show at	_	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o								10d. Inside City Limits
	the Ma 28a-f	recto	Maryland Baltim 10e. Street and Number	ore	I	Oundall				T	10a. Citize	en of What C	1 ☐ Yes 2X No
	th with 23a or st be r	al Di	7427 Waymouth Way			101. 21		21222	2		reg. em.	USA	,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 XDivorced	12. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	ver in U.S.	13. Was Dece If Yes, spe 1 Yes		ispanic Ori n, Mexican Specify:	gin? (Spe i, Puerto F	cify Yes or No- Rican, etc.)		Black, Wh	nerican Indian, uite, etc. White
21215-0036	thin 72 hou e. an "natural Medical Ex	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)	ducation	+)	ecedent's Usu live kind of wo le. DO NOT u	ork done d se retired	during mos)	t of workir	ng		d of Busines	ŕ
	filed with Hygiene. Ither thar nt, the M	S	12 years 17. Father's Name (First, Middle, Last)			Electri	lciar		er's Name	(First, Middle		struc Surname)	tion
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Mary	2 shouland Manal		19a. Informant's Name/Relationship (•	,			l Route Numb			
	1 and 2 Health tem 27		Derek Marmen 20a. Method of Disposition	son	20b. Place of D				voven				aryland 21220 or Town, State
E OE	Pages nent of h int: If lte		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Bayvier			e) ¦ [7	17, 2	1011	Balt	imore	,MAryland
Baltimore,	permit. Pag Department Important: i any injury o		21. Signature of Funeral Service Licen	100	61176	Conne 7110	nd Addre Lly F Solle	unera ers Po	l Ho Sint	me Of Road,	Dunda Dunda	lk,P.	A. 21222
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	/Medical Examiner		resulting in death)	Due to (or as a	a consequence of)								
	ite be executed iysician and ihe burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence of)								
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P.O. Box 6	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of Live birth 4 Pregnant at 9 Unknown	2 - Fetal death	3 Ectopic 5 Other (s)		·			23	3d. Date of o	delivery Day Year
	ires that t signed by Id be deta	by	Part II. Other significant conditions of	contributing to death be	ut not resulting in t	he underlying	cause gi	ven in Part	I.	23e. Did 1		se contribute	e to the cause of death? Probably 4 Vunknown
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Vita	sician: Th certificate irector, pa	Be	25. Was case referred to medical examiner?	Hospital:			Othe	or.		(Check only o			
	ing Physi After this c funeral dir	ion: To	1 Yes 2 WNo 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injur (Month, Day	y 28b. Tim	e of	28c. Injur Work	y at	2	ne 5 Resi 28d. Describe			pecify)
Division	or Attend after death Director: / in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined		ry - At home, farm . (Specify)			100 2		28f. Location City or Tov		Number or	Rural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	Medical Co		nysician: To the best o miner: On the basis of and manner sta	examination and/o								
	To the within To the Compl	Me	29b. Signature and title of certifier				c. License				29d. Date	signed (Mo	onth, Day, Year)
	/		1 / me				D-0	0061	115		Nov	ember	14, 2011
18	o√			completed cause of d		pe, Print)		49	40 Ea	stern A	venue	, Baltin	nore, MD, 21224
	Sta Registi		31. Date filed (Month, Day, Year)		s's Signature	park	,						

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hilip Macht		For State	tate of Maryland		tment of He <i>ificate of De</i>		ental Hygiene	Reg. No. 2	9 11 3690
Physician	7	egistrar . Decedent's Name (First, Midd	lle,Last)				2. Date of D Month	eath	3. Time of Death 0425 hrs
Medical Examine		PHILIP	and attent and pumber		CHT	ity, Town, or Locat		Day Year er 14, 2011	
		 Facility Name (if not institute 2301 Cross Country I 			1	altimore		N/	
Funeral		5. Social Security Number		e (In yrs. las			Under 24Hrs. 8. Date of		
Director		216-22-3945	1XM 2F	83	Yrs.	lonths Days H	lours Min. 09/2	8/1928	Country) MD
any	-	Jsual Residence of Decedent Oa. State 10b. County		10c. City, T	Town or Location				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	5 L	MD N	1/A		BALTIMOR				1 X Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traunatic event, the Medical Examiner must be notified at once.	Ulrector	0e. Street and Number			10	f. Zip Code		10g. Citizen of Wha	at Country?
ith the		2301 CROSS (COUNTRY BLVD.		13. Was De	21209 cedent of Hispanio	Origin? (Specify Yes or	USA No- 14. Race -	American Indian, Black,
eath w	Funeral	1 Never Married 2 N	Armed Forces			pecify Cuban, Mex	kican, Puerto Rican, etc.)	White,	etc.
after d	<u>y</u> -		vorced If Yes, Give Year or Dates:			2 X No spe		Specify:	WHITE
hours Exam		15. Decedent's Education (Spe Elementary/Secondary (0-12)				sual Occupation (0 of working life. DO	Give kind of work done NOT use retired)	16b. Kind of Bus	siness/industry
36 hin 72 e. than	Completed	Elementary/Secondary (0-12)	5	··/	BUILD	ER		REAL	ESTATE
5-00 ed wit lygien other	탕	17. Father's Name (First, Middle	e, Last)			18.M	other's Name (First, Middl	e, Maiden Surname)	
21215-0036 Juld be filed within 7 I Mental Hygiene. In marked other than ic event, the Medica	8	MORTON		CHT	40h Mailine Ad	S(OPHIA Number or Rural Route N	lumber City or Town	ROMM
MD 2: nd 2 should alth and M on 27 is m:	2	19a. Informant's Name/Relation LOIS MACHT/W]			1		TRY BLVD., B		
e, M and 2 Health item 2		20a. Method of Disposition			lace of Disposition	(Name of cemeter		20c. Location - 0	City or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 4 Donation 5 Other S		ate A	rematory or other p RLINGTON MUNO CEM	CHIZUK	11/17/201	1 BALTI	MORE, MD _
altir mit.] spartm sports iury o	Ì	21. Signature of Furreral Service	Licensee		22. Name	and Address of F		NSON & BR	OS., INC.
1.5	1	23a. Part I. Enter the disease, o	manications that caused	the death	8900	REISTERS	STOWN ROAD,	PIKESVILL arrest, shock, or hea	E MD 21208
Physician /Medical		failure. List only one cause	e on each line.				,		Between Onset and Death
xaminer	-	Immediate Cause (Final diseas or condition resulting in death)	Due to (or as a cons						
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ie be executed te be executed ysician and burial - transit	edica	UNPENDED	AMENDED						
760, cate be physici	ĕ¦	IF FEMALE: 3b. Was decedent pregnant in	23c. If yes, outco	me of pregn	_			23d. Date of o	delivery Day Year
r 68° certificant	ig (past 12 months?	I LIVE DITTI	t time of dea	2 Fetal o	leath 3E (Specify)	ctopic pregnancy	Monar	Day
Boy e death the ath	Physician/M		9 Unknown					d tabassa usa santrii	bute to the cause of death?
that the ned by detach	함	Part II. Other significant cond	Itions contributing to dea	th but not re	sulting in the unde	rlying cause given	militari.	_	Probably 4 Unknown
duires sen sign	됩				_		24a. W		Vere autopsy findings available
COTC law re has be	Completed						pe	erformed? d	rior to completion of cause of leath? Yes 2 No
H. The tiffcate or, page		25. Was case referred to medic	al			26.Place of D	Death (Check only one)	es 2 No 1	Yes 2 No
/ital /ysiciar ysiciar his cer directo	o Be	examiner? 1 ✓ Yes 2 No	Hospital: 1 Inpati	ient 2	ER/Outpatient 3	DOA Othe	Ya Nursing Home 5	Residence 6	Other: Scene
Division of Vital Records, P.O. Box 6876. 1st or Attending Physician: The law requires that the death certificate as after death. 1st Director. After this certificate has been signed by the attending phylogon in by the fineral director, page 2 should be detached for use as the beautiful to the fineral director.	⊢ ի	27. Manner of Death	28a. Date of Inj (Month, Day, NoV 14, 201	jury Y ^{ear)}	28b. Time of Injur 0340 hrs		— Subject s	be how injury occurre hot self	ed
Sion ttend death. ctor:	턣	E Pe	estigation		ome, farm, street, f	1 Yes		n (Street and Number	er or Rural Route Number, City
Divis	Certification:	del	uld not be (Specify) Si			actory, office builds		n, State) s Country Blvd., B	
hou hou		(0	Physician: To the best of r	ny knowledo	ge, death occurred	at the time, date a	nd place, and due to the	ause(s) and manner	as stated.
To the within To the comple	edical	- (5	aminer:On the basis of examiner stated		nd/or investigation	in my opinion, dea			ed (Month, Day, Year)
	Σ	29b. Signature and title of certification in the control of the certification in the certific	roisse // M	6		O.C.M.E		November	
50 v		30. Name and address of person Melissa Brassell, MD	·			Baltimore Stree	et, Baltimore, MD 2	1223	
Sta	ate	31. Date filed (Month, Day, Yea	r) 32 Registr	ar's Signatu					·
Registr		NOV 1 8	2011 Janua	· M.	parke				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36908 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Joan Nengel 10:50 2011 A M November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 1448 Overlook Way Bel Air Harford . Social Security Number If Under 1 Year 9. Birthplace (State or Foreign Country) Baltimore Maryland 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Days Hours Min 1 □ M 2 🛛 F 70 August 17 1941 217-38-8478 **Director** Usual Residence of Decedent 28a-f show iral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 🗆 Yes 2 🔀 No Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1448 Overlook Way 21014 U.S.A. 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? ✓ Yes 2 💆 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: White Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Banker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Wilson T. French Constance McVeigh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Cary Nengel (Spouse) 1448 Overlook Way, Bel Air, Maryland 21014 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Befall Mellorial the place, 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State November 19, Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Evans Funeral Chapel & Chemation Services - Bel Air
3 Newport Drive, Forest Hill, Maryland 21050 Funeral Service Licensee Jeffrey R. Testerman (MO1543) P It 1. Enter the disease, or complications that caused the death. Do not enter shoot, or wart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical ue to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of) resulting in death) Last physician s the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 410 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be Hospital 1 ☐ Yes 2 ☑ No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Pesidence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title of certifie

State Registrar person who completed cause of death (Item 23a) (Type, Pri

32. Registrar's Signature

th, Day, Year)

Please Type or Printin-Black-Indelible Inks Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 201 for State Registrar 36909 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 11 5:51 P Gilbert John Nadolny 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bridgewater Rd. Ocean Pines Worcester 5**218-28:18364** 218-18-8364 **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign X M 2 □ F Days 80 Months Hours 10725 1931 Country) Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified 28a-f MD Worcester 1 Yes 2 No Ocean Pines 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? be ms 23a c Funeral permit. Page 1 and 2 should be filed within 72 hours after death with 4 Bridgewater Rd. 21811 USA items ; 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No
If Yes, Give Black, White, etc. o ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: "natural", 3 Widowed 4 Divorced white Completed Korean Year or Dates of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Set Up Man Western Electric Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John J. Nadolny Viola Wisnowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 is any injury or other traus William Smith / Son in law 316 Stone Run Dr., Rising Sun, Md 21911 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
\$t. Stanislaus Cem. 20c. Location - City or Town, State Date 1 Burial 2 ☐ Cremation 3 ☐ Remo 11/15/2011 Baltimore, Maryland 5 Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Dundalk Marvland 21222 Uneral Sery ature 7922 Wise Ave. Dundalk, Maryland Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Onset and Death Immediate Cause (Final Ph_sician/ 10 State ancer disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Physician/Medical Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Day Month Year Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performe After this certificate Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certific. funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: ျှ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) 4 Nursing Home 28a. Date of injury (Month, Day, Year) 27. Man of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident 1 Yes 2 No Investigation completed filled in by the 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one) 29b. Signature and title of certifier 29c. License number 30. Name and addre of person who completed cause of death (Item 23a) (Type, Print) Ocean 11107

DHMH 17 Rev 7/2009

State

Registrar

18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Nonth Pember Medical NACHBAR Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SHADY GROVE MEDICAL CENTER ROCKVILLE MONTGOMERY Social Security Number **Funeral** 6. Sex 1 ፟፟ M 2 ☐ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth **Director** 073-40-6465 Months Days Hours 05/04/1964 Usual Residence of Decedent 28a-f show "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State **Funeral Director** 10b. County 10c. City, Town or Location 10d. Inside City Limits MONTGOMERY GAITHERSBURG 1 Yes 2 X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 9958 FORESTVIEW PLACE 20886 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black, White, etc. If Yes, Give Year or Dates 1 ☐ Yes 2 🕅 No Specify. Completed 3 Widowed 4 Divorced Specify: WHITE marked other than "natural mattic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MEDIA ADVERTISING CONSULTANT Be MEDIA 17. Father's Name (First, Middle, Last) ortant: If item 27 is marked or injury or other traumatic eve 18. Mother's Name (First, Middle, Maiden Surname) ၉ permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic s **JERRY** NACHBAR TOBY FORMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHERRY NACHBAR / WIFE 9958 FORESTVIEW PLACE, GAITHERSBURG, MD 20886 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 🗌 Cremation 3 🕅 Removal from State 4 Donation 5 Other (Specify) WELLWOOD CEMETERY 11/18/2011 PINELAWN, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Physician/ cance Onset and Death Medical Due to (or as a consequence of). **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or imjury that initiated events resulting in death) Last as the burial-Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 1 Yes 2 9 Unknown Pregnant at time of death Dav g Unknown Year Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Metastatic disease to 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed Yes 2 death? 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Tyes 2 No this Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) completed filled in by the funeral 27. Manner of Death
1 Natural
2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 5 Pending Accident Investigation 3 Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHANALES SHADY GROVE RD RURKVILLE MD 20850 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3691 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Louis Bernard Oldewurtel, Jr. 1:30P 2011 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 640 S. Oldham Street Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Age (In yrs. last birthday) **Funeral** Days Hours (Month, Day, Year) 220-38-5020 Director 1 XM 2 □ F 69 Maryland 12-14-1941 show 10d. Inside City Limits ms 23a or 28a-f shorms the notified at 10b. County 10c. City, Town or Location Director X Yes 2 No Baltimore 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21224 640 S. Oldham Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc ٩ ģ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates. 1960-1966 the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hyglene. 27 is marked other than " r traumatic event, the Mec Elementary/Secondary (0-12) College (1-4 or 5+) Wire Company Galvaniser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Elsie J. Dobson Louis B. Oldewurtel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 S. Lehigh Street Balto. Md. 21224 spouse Doris Oldewurtel 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot once. cemetery, crematory or other place, 11-16-2011 Glen Burnie, Md. Atlantic Crematory 4 Donation 5 Dother (Specify) 21. Signalure of Funeral Service Licensee Charles S. Zeiler & Son, Inc. 22. Name and Address of Facility Balto. Md. 21224 6224 Eastern Avenue 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Ischemic heart disease Years resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter decembing Be Completed by Physician/Medical Examiner Due to (or as a consequence of): Cause (Disease or injury that initiated events resulting in death) Last 28 Due to (or as a consequence of) Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Year Pregnant at time of death Yes 2 No 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertension 1 🙀 Yes 2 □ No 3 □ Probably 4 □ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? certificate has blirector, page 2 s perform Yes 2 No 25. Was case referred to medical examiner? Division of Vital filled in by the funeral director, 26. Place of Death (Check only one) Hospital: Other: မှ 1 🗌 Yes 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗹 Residence 6 ☐ Other (Specify) Medical Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred after death. Director: After Natural
Accident
Suicide 5 \square Pending work?
1 Yes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours at To the Funeral D completely filled i Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 10035363 erson who completed cause of death (Item 23a) (Type, Print) Greene St. BVAMC larshallmo 10

DHMH 17 Rev 06-2011

State Registrar 31. Date filed (Month, Day, Year)

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		For State Registrar	State of IV	-	•	ment of F ficate of D		nd Mental Hy	/giene Reg. No.	201		36912
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ore, Maryland 21215-0036 te 1 and 2 should be filed within 72 hours after death with the Maryland tof Health and Mental Hygiene. If item 27 is marked other than "natural", or items 28a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at	by	11. Marital Status 1 ☐ Never Married 2 ☒Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.			Decedent of Hies, specify Cuba		? (Specify Yes or No uerto Rican, etc.)		14. Race - A Black, W Specify: Wh	/hite, etc.	
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Baltimore, Maryland sermit. Page 1 and 2 should be filed bepartment of Health and Mental Hy, mportant, if item 27 is marked oth any injury or other traumatic event, once.	To Be	17. Father's Name (First, Middle, Last) James Pulaski					Cathe	Name (First, Middle erine Kos:	inski			
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Baltimore, Misser Baltimore, Misser Bermit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other transones.		20a. Method of Disposition 1 Rule Burial 2 Cremation 3 4 Donation 5 Other (Spec	Removal from State	20b. Place of cemeter Garden	rv. cremato	ory or other plac	:	ovenber 21, 2011		cation - City timore		, State aryland
Balt permit. Departi Import any inj		21. Signature of Funeral Service Licer	see Canne	elly	^{22. N} Coi 71	ame and Addres nnelly 1 10 Solle	s of Facility Funera ers Po	l Home of int Road,	Dund Dund	alk, l alk,M	P.A. 1. 2	1222
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760 cate be executed physician and s the burial-transit	ical Examiner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	с	a consequence of								
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ع المظامة ح	Certificate:	2 Accident Investigation 3 Suicide 6 Could not 4 Homicide determined	28e. Place of In	jury - At home, fa tc. (Specify)			Yes 2 □ N	28f. Location	(Street and own, State)		- Rural Ro	oute Number,
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To the Hosp within 24 ho To the Fune completely f	Σ	only one) 3 🛣 Certifying Nu 29b. Signature and title of certifier	se Practitioner: To t	2	meuye, de	29c. License		7_		e signed (M		
13~		30. Name and address of berson who					mTree	NITIM W	21002	1101	<u>~ 1 </u>	
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11-08549 Steven Pennington Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2011 36913

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Division of Vital Records, P.O. Box 68760, ital or Atteodiog Physician: The law requires that the death certificate be executed as there death.	filled in	Certification:	dete	d not be rmined		Interse		, , , , , , , , ,	, , , , , ,	,,			or Town, Presbury Str	State)				
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-		ŀ	30. Name and address of persor	who com	pleted caus	se of death	(Item 23a)	-										
			Pamela E. Southall, M		ssistant				W. Ba	altimore	Street,	Baltin	nore, MD 2	21223				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month . Decedent's Name (First, Middle, Last) Day 15 **Physician** 1:55 PM Frances Pusinsky 11 3011 /Medical County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Jown, or Location of Death Examiner Franklin Hospital Center Square 8. Date of Birth Sept 18, 1940 . Age (In yrs. last birthday)
71 Yrs. 9. Birthplace (State or Foreign Social Security Number **Funeral** Months Davs Maryland 213-36-2254 1 ☐ M 2 🖫 F Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director Dundalk Md. Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7655 Charlesmont Road 21222 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 🛂 No 21215-0036 Specify White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event. 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Bernard C. Bowman Doris Groft 19a. Informant's Name/Relationship (Type. Prir Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph John Pusinsky, Sr. 7655 Charlesmont Road Baltimore, Md. 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition November 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Gardens of Faith 19,2011 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Kaczorowski Funeral Home, P.A. M00933 1201 Dundalk Avenue Baltimore, Md.21222 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Carcinomo Physician disease or condition resulting in death) / /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. δ 1 ✓ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☑ No 2 🗆 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Hospital or Attending 5 Pending within 24 hours after deau...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) 29c. License number 29b. Signature and title of certifier 55 171

State Registrar 30. Name and address of person w

Selbastian John

31. Date filed (Month, Day, Year) 32. Registrar's Signature

Secretar's Signature

9000 Franklin Square Dr.

impleted cause of death (Item 23a) (Type, Print)

1200

Baltimore, MD 21237

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November 2011 9:30 Lillian Allistyne Rahming AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Baltimore Northwest Hospital Randallstown Social Security Numbe **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 1 □ M 2 X F Hours 5-20-1920° MD **Director** 127-20-7874 Usual Residence of Decedent or 28a-f show notified at 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? be items 23a Funeral USA 6828 Campfield Road 21207 12. Was Decedent Ever in U.S. Armed Forces 3 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, 0 þ 1 Never Married 2 Married Specify: African-American Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 ☐ Divorced Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the ME Elementary/Seconday (0-12) 12th College (1-4 or 5+) Bookkeeper Brooklyn Junior Academy Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Laurence Jerone Harris Lillian Warren 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 6828 Campfield Road, Gwynn Oak, MD 21207 Valerie Rahming/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Metro Crematory 20c. Location - City or Town, State 1 🗆 Burial 2 ី Cremation 3 🗔 Removal from State 11-16-2011 Baltimore, MD 4 Donation ,5 Other (Specify) 21. Sign, un of Furieral Service Licensed 22. Name and Address of Facility Wylie Funeral Home P.A. of Balto. Co. 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph, sician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami burial-transit and Due to (or as a consequence of) resulting in death) Last After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? Pregnant at time of death 4 ☐ Pregnant : g ☐ Unknown g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the upon ying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director, After this certifics completed filled in by the funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Other: ၉ patient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 atural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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	Examin		4a. Facility Name (if not institution, gi			4b. City,	Town, or	Location of	of Death		40	. County of D	eath	
			213 Hazel Avenu				ansd		OA Um	- 5				nore
	uneral irector		5. Social Security Number 6. 281-18-5864	Sex 7. Age 1	(In yrs. last birthda	Months		If Under Hours	Min.	8. Date of Bir (Month, Da			Birthpl Co <i>unti</i>	ace (State or Forei y)
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Baltimore, Maryland 21215-0036 bernit. Page 1 and 2 should be filed within 72 hours after becartment of Health and Mental Hydiene.	e. nan "natu Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)		(Gi	cedent's Usu ve kind of wo DO NOT us	rk done di	ation <i>uring m</i> osi	t of workin	g	16b. k	Kind of Busine		
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Division of Vital Records, P.O. Box 68760 to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.	been signed by the attending ph should be detached for use as t	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		2 Fetal death	Ectopic		у			Ì	23d. Date of Month		ry Day Year
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f Vi	this cral dir	2	1 Yes 2 YNo 27. Manner of Death	1 _ Inpation	ent 2 ER/Outpa		OA Dine 28c. Injury	4 ∐ N		ne 5 Resi		6 Other (S	pecify)	
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41			30. Name and address of person wh	o completed cause of d	eath (item 23a) (Typ	9 L A). P	e/lin	1 £	d B	011	imale	,	W 212
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ORIGINAL

Please Type or Print in Black Indelible Ink. 578/20 All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month 14:55 PM Roseborough Medical 4a. Facility Name (if not institution, give sheet and number) 4b. City, Town, or Location of Death Baltinose 4c. County of Death **Examiner** of Maryland ical W. 7 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 220-36-0899 1 M 2 F Hours Director Usual Residence of Decedent 28a-f show 10h. County 10a. State City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 Yes 2 No more ъ 10e, Street and Number 10g. Citizen of What Country? items 23a USA 21215 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. o, 1 NeverMarried 2 Married Completed by 1 Yes 2 If Yes, Give Year or Dates. 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", 3 Widowed 4 Divorced 19 the Medical 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DenyOT use retired)

16a. Decedent's Usual Occupation

16a. Decedent's Usual Occupation

16a. Decedent's Usual Occupation

16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry nd Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Dervi edem traumatic event, Be 17. Father's Name (First, Middle, Last) other's Name (First, Middle, Maiden Should be filed h and Mental H 7 is marked of ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health a item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Department of Important: If it any injury or o ŏ ■ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee arene Funeral Bervices 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Unterior Communicating artery orneurysm da Medical Due to (or as a consequence of) Examiner asytemsion Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to for as a consequence of): attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death signed by the at Id be detached for 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Yes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an Director: After this certificate has 2 2 100 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X10 Other: ၉ 1 Yes 1 Department 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred To the Hospital or Attending iniury work?
1 Yes 5 Pending death. 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined hours after City or Town, State) within 24 hours a

To the Funeral D Medical 29a. Certifier 1 🚅 Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) AU4176435B100552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brown ristophe GIRENE St 0490 MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36918 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ November F. Ritchie 16, 2011 7:29 РМ Alice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Social Security Number **Funeral** (Month, Day, Year, Director 95 214-12-0083 1 □ M 2 🗓 F August 18,1916 Nicaraqua Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b County 10c. City, Town or Location Director must be notified 1 Yes 2 XNo Nottingham Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? o 23a Funeral 21236 USA 8348 Cypress Mill Road items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 1. Marital Status Examiner Armed Forces? Black, White, etc. 0 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 X Widowed 4 Divorced other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4 or 5+) Housewife Own Home 7 vears Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Alice LeRoiz William Walton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other 8348 Cypress Mill Road, Nottingham, Maryland 21236 daughter Alice Clark 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State November cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Timonium, Maryland 21, 2011 Dulaney Valley Mem. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Servi 20 Name and Address of Facility Towne Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Maryland 21222 Rart J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onset and Death Immediate Cause (Final emantra Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of, cause. Enter Underlying Cause (Disease or injury that initiated events burial-trar Due to (or as a consequence of): resulting in death) Last the at ending physician Physician/Medical dea h certificate be Box 68760 as the I IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death detached for use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Dav Pregnant at time of death Unknown 9 Unknown Division of Vital Records, P.O. signed by ted be seen to be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🔲 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2: autopsy performed 2 🗆 No 1 Tes Yes 2 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 2 Accident 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 5 Pending work? 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signaty title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) November 172011

Registrar
DHMH 17 Rev 06-2011

State

31. Date filed (Month,

MARIES

6701

ddress of person who completed cause of death (Item 23a) (Type, Print)

M

CHARLES

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 01 Physician/ November 17, Speiden 1 07004 Michael Raymond Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Casey House Rockville Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Jan 31, Ye17936 Washington DC 577-50-4774 **Director** 1**X** M 2 □ F 75 , or items 23a or 28a-f show iminer must be notified at 10a. State 10d Inside City Limits death with the Maryland 10c. City, Town or Location Director 1 Yes 2 No Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 13001 Narada Street 20853 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian "natural", or iter edical Examiner Black, White, etc. þ 1 Never Married 2 Married Yes Yes, Give within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: White 3 Widowed 4 XDivorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) 2 should be filed within 72. It and Mental Hygiene. 7 is marked other than "I Elementary/Secondary (0-12) College (1-4 or 5+) Banker Financial Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert Speiden Mary Howells 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
92 Coulson Drive Colora, MD 21917 mit. Page 1 and 2 st partment of Health a portant: If item 27 is y injury or other tra William R. Speiden/son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of Important: If it any injury or o once. cemetery, crematory or other place) 1 Burial 2 XCremation 3 Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 11/18/11 Woodbine, MD 21. Signature of Funeral Service Licer Sing Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Ph_sician/ Idiopathic Fibrosing Alveolitis disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of and that initiated events physician are the burial-t resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month 5 Other (specify) Day Year Pregnant at time of death by the Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has death? performed 1 ☐ Yes 2 ☐ No Yes 2 X No Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) hospice After this 27. Manner of Death completely filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending 2 Accident
3 Suicide Investigation Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 — Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and tiple of certifier 29c. License number 29d. Date signed (Month, Day, Year) R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP 6001 Muncaster Mill Rd. Rockville, MD 20855 31. Date filed (Month, Day, Year) 32. Registrar's Signature NOV 1 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar		State	ot iviaryiar	та / Бер Се	artmen <i>rtificate</i>	of D	eaim a eath	and iv		Reg. No.	201		369	20
Physicia	an/	1. Decedent's Nam									2. Date of Dea	Dav	Yea	ar	3. Time of Dea	- 1
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Examir	ner	Kline Hos		_	ribery		2"	Airy		n Death			ederi			i
Funeral		5. Social Security N	-	6. Sex	7. Age (In yrs.	last birthday)	If Under Months		If Under 2	24 Hrs. Min.	8. Date of Bir	th v Year)	g.	Birthpla	ace (State or For	reign
Director		220-24-03 Usual Residence		1 □ M 2 X F	97	Yrs.	WIOTITIS	Days	710010		Nov 17	, 191	3 Ne	Ū W	ersey	
and show	5	10a. State	10b. County	,	10c. Ci	ity, Town or Lo	ocation							10	d. Inside City Li	mits
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h the	a B	10e. Street and Nur 4614 Urba		F.O.			10f. Zip					10g. Citiz	en of What	Count	ry?	
ING Z1Z15-UU36 filed within 72 hours after death with the Maryland al Hygiene. d other than "natural", or items 23a or 28a-f sho went, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	and Pir		edent Ever in U	S 13			nanic Oric	nin? (Sne	cify Yes or No-		4, Race - A	morica	n Indian	
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Te, 1 and of Hea of Hea f item		20a. Method of Dis		0 0 0 1/		Place of Disp cemetery, cre	osition (Nan	ne of ther place	e)		Date	20c. Loc	cation - City	or Tov	vn, State	
Baltimor permit. Page 1 Department of Important: If it any injury or o		4 Donation	5 Other (Fir	nal Jou	ırney	Crem	atory	7 11/	′17/11	Wood	dbine,	MD)	
baltimore permit. Page 1 a Department of I Important: If ite any injury or ot once.		21. Signature of Fu	meral Service	icensel 14	/ MO1:	G G	2. Name an	d Addres	s of Facility	tior	Servi	ce I	.O. E	3ох	784 MD 210	120
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deaho deaho he a ter	Physician/N	in the past 12 1 ☐ Yes 2 ☐ 9 ☐ Unknowr			gnant at time of		Other (sp		у		_		Month	I	Day Year	
that the				ons contributing to	death but not re	sulting in the	underlying	cause giv	en in Part I	l.	23e. Did t	obacco us	se contribut	e to the	e cause of death	1?
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DIVISION tal or Attendir rs after death. al Director: Af	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could deterr	minod 28e. Place	e of Injury - At h		reet, factor	, office			28f. Location (City or Tov		Number or	Rural I	Route Number,	
spital cours at ceral D filled i	edical C	29a. Certifier	1 V Certifyin	g Physician: To the	best of my know	wledge death	occurred a	t the time	. date and	place, ar	nd due to the c	ause(s) an	d manner a	is state	d.	
DIVISION OF VITAL RECORDS, P.O. BOX ON To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the a fending completely filled in by the funeral director, page 2 should be detached fir use a	Medi	. (Check 2	2 Medical	Examiner: On the bag	asis of examination	on and/or inve	stigation, in	my opinio	n, death oc	ccurred at	the time, date	and place,	and due to t	the cau	se(s) and manner	r stated.
with Voit to the Source of the		29b. Signature and	title of certifie	er // _				. License 01756					signed (Mender 1			
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	Physiciar	_	I. Decedent's I	Name (First, Middle	Last)								2. Date of Do Month Octobe	eatn r 28	y 20	1 ^{Year}	11:45 AM	
	Medica	al _	Dougla	s L. Smi	give street	and number)			4b. City, T	own, or L	ocation c	of Death	00000	4c	County	of Death		
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Maryland	d Meni marke		19a Informa	nt's Name/Relations	ship (Type, F	Print)		19b. Mail	ing Address	(Street a	nd Numb	er or Rui	al Route Num	ber, City	or Town,	State, Zip	Code)	
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iore,	ge 1 and it of He : If item or othe		1 🗆 Bur	of Disposition	3 🗆 Rem	noval from St	ate (Place of Disp cemetery, cre	ematory or c	ther plac	- 1		Date					
Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 20a or 28a-f show important: If item 27 is marked other than "natural", or items 20a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.			nation 5 X Other or Funeral Service Ronald	_	3///	rector	2	22. Name ar	nd Addres	ss of Faci	inySta	ite Ana St; B	tomy alti	Boa more	rd • MD	21201	
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68760	certific inding use as	an/M	IF FEMALE: 23b. Was de	ecedent pregnant	23c	. If yes, outco	irth 2 🗌 Fe	etal death	B Ctopic		су					Date of de Vlonth	blivery Day Year	1
Вох	death he atte	sick	in the p	es 2 No		4 Pregna g Unkno	ant at time of own	f death 5	Other (specify) _								
P.O.	hat the ed by t detach	Completed by Physician/Medic	Part II. Othe	er significant cond	tions contr	ibuting to de	ath but not re	esulting in th	e underlying	g cause g	iven in Pa	art 1.					o the cause of death? Probably 4 Unkno	wn
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cor	aw requals bee	nplet												autopsy performed	1?	prior to death?	completion of cause c	of
Re	r: The licate h	So	25 Was cas	se referred to medic	al					26. F	Place of E	Death (Ch	eck only one)	Yes 2	- NOI_	-10 1		
Vita	ysiciar s certii directd	To Be	examine	er?				☐ ER/Outpa		DOA		Nursing	Home 5				ecify)	
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Division of Vital Records,	Attending Physician: The law requires that the death certificate be ar death. ector: After this certificate has been signed by the attending physicii by the funeral director, page 2 should be detached for use as the bu	Certificate:	2 □ Ad 3 □ Su 4 □ Hd	iicide 6 🗌 Co	estigation uld not be ermined	28e. Place	of Injury - At	home, farm,	street, fact	ory, office			28f. Locat City o	ion (Stree r Town, S	t and Nui tate)	mber or R	Rural Route Number,	
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	To the To the comp		29b. Signa	ture and title of cert	ifier				12	29C, Licer	ise numb	143	3	1	love.	mb	25 9, 700	1
			30. Name	and address of pers	on who cor	npleted caus	e of death (tem 23a) (Tyr	pe, Print)	1 .	<u> </u>			140	71	778	r as stated. nth, Day, Year) 25 9, Zod	
			JV	18ock IV	MO	11	ZON	Vall hature	my 1	Rd	(21)	msc	MLC !	2	Cle			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36922 Reg. No. 2 Certificate of Death 2. Date of Death zostak Day Month Physician/ 3:30 Medical 4b. City, Town, or Location of Death 4a. Facility Name of not institution, give street and number, 4c. County of Death **Examiner** BEL AIR JPPER CHESAPEAKE MEDICAL CENTER Hartord Birthplace (State or Foreign Country) 5. Social Security Number yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months 216-22-4822 MD **Director** Usual Residence of Decedent 10d. Inside City Limits or 28a-f shown notified at 10a. State 10b. County 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No BEL AIR HARFORD MD 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number items 23a or ner must be n UŠA Funeral 21014 555 S. ATWOOD RD Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after dea Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner once. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) NAIL MANUFACTURE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ANNA SOELLNER မ EMMANUEL SEVICK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) BEL AIR, MD 21014 719 HUGH PLAIN DR DONNA KACKOWSKI-DAUGHTER Baltimore, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date HOLY REDEEMER 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MD 11/14/11 4 Donation 5 Other (Specify) SCHIMUNEK FUNERAL HOME OF BELAIR 21. Signature of Funeral Service Licensee 22. Name and Address of Facility BEL AIR, MD 21014 610 W. MACPHAIL RD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph. sician/ Fronte days disease or condition Medical resulting in death) Due for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24a. Was an Were autopsy findings available prior to completion of cause of autopsy perform 1 Yes 2 No certificate Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Division of Vital Certificate: To Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending within 24 hours after death. To the Funeral Director; A Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 1 *Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or inventionties. In the state of the cause of examination and/or inventionties. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 29b. Signature and title of certifier 00056607 Novamber 11th 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PLUMTREE Rd, Suit D BELAR

Registrar

JUSEPH

31. Date filed (Month, Day, Year)

ANGIELO.

MD

32. Degistrar's Signature

DHMH 17 Rev 7/2009

208

11-08593 John

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

John Craig Smith	1	State	e of Maryland	/ Depar	tment of	Health	and	Menta	l Hygien	е	20		36923
		For State		Certi	ficate of	Death				Reg.	No. 20		e of Death
Physicia	n/ ľ	Decedent's Name (First, Middle,La John Craig Smith								th Diember 1	ay Year 5, 2011	13	37 hrs
Medical Examir	lei 7	la. Facility Name (if not institution, g	give street and number)		41	o. City, Tov		cation of [Death		4c. County of De Baltimore C		
		4707 Raspe Avenue				Baltimo If Under		If Under 2	24Hrs 8 Da	te of Birth(MM/DD/VVVV 9	Birthplace	(State or
Funeral	- 1	o oodia, oodani, ri		e (In yrs. las		Months		Hours		y 20,	For	eigr [[O w Country)	rson, MD.
Director	L	212-82-5949 1 Usual Residence of Decedent	X M 2 F	- 52	Yrs.								
y as		10a. State 10b. County		10c. City, T	own or Location	on							nside City Limits
Maryland 28a-f show d at once.	5	-	I/A	Ba	altimor		a da			10a	Citizen of What C		
Maryl r 28a-1	60	10e. Street and Number				10f. Zip C		20 6			United		es
rith the Maryland 23a or 28a-f show grotified at once.	a D	4707 Raspe Avenu	12. Was Deceden	t Ever in U.S	i. 13. Was	Decedent	of Hispa	anic Origin	? (Specify Y	es or No-	14. Race - An White, etc	nerican Inc	
eath w	Funeral	1 XNever Married 2 Marri	ied Armed Forces	? X No					Puerto Rican,	etc.)		 White	_
after d	D F		ced If Yes, Give Year or Dates:	(atast) T	116a. Decedent	Yes 2	_		nd of work do	ne 1	Specify: 6b. Kind of Busine		
hours fratur Exam	Eg .	15. Decedent's Education (Specify Elementary/Secondary (0-12)	College (1-4 or		during mo	st of work	ng life. [OO NOT u	se retired)				
36 thin 72 te. than '	Completed	11	N/A		М	ainte			pervis			sgil	l Retire.
5-0036 iled within 7 Hygiene. I other than		17. Father's Name (First, Middle, La									iden Surname)		
2121 2121 Mental marked ic event,	o Be	Albert John Smit 19a. Informant's Name/Relationship			19b. Mailing	Address	(Street	and Numb	sa Mar per or Rural R	oute Numb	er, City or Town, S	tate, Zip (Code)
MD 2 d 2 shoulth and M m 27 is n	٤	Mr. John Scott S		ther)		lkin					aryland 20c. Location - Cit		236
_ 5 % 5 6		20a. Method of Disposition 1 Burial 2 Cremation	3 Removal from §		Place of Dispos rematory or oth			~a	Date Thursd	av.	(Harfor	rd Co	unty)
Pages nent of		4 Departion 5 Other Spec	cify:	Crea	maion Ser	viœs	Inc.		Nov. 17,				Maryland
Baltimore, permit. Pages 1 a Department of the Important: If its injury or other to injur		21. Signature of Funeral Service Li	//	T. 2 - 18.00	~~~	222	` \Zi	le David	l mim	wiim k	forest and 2	/1093_	2215
Physician		da Part I/Edter the disease, or confailure. List only one cause of	omplications that cause	d the death.	Do not enter ti	he mode o	dying,	such as ca	rdiac or respi	ratory arres	st, shock, or heart	Ap	proximate Interval etween Onset and
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Examiner		or condition resulting in death)	Due to (or as a con	sequence of	f):								
	ler	Sequentially list conditions, if any, leading to immediate	Due to (or as a cor	sequence of	F):								
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OX 687 eath certific	sicia	past 12 months?	7	at time of de	eath 5 0	ther (Spec	cify)						
O. Boor rethe death by the at ached for	Physici	Part il. Other significant condition			esulting in the	underlying	cause g	iven in Pa	rt I.		pacco use contribu		
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ecol he law ate has	E O									Yes 2		Yes	2 No
Vital Rec yrician: The his certificate director, page	Be C	25. Was case referred to medical examiner?	11 11 11		1		26.Place	of Death	(Check only o		Residence 6	Other: Sc	ene
F Vit Physic arthis		1 Yes 2 No 27. Manner of Death	28a Date of	atient 2	ER/Outpatier 28b. Time of			ry at Work	? 28d.		now injury occurred		
on of anding Ph. th. r: After 1 te funeral	ion	1 Natural 5 Pend			FOUND: 1330 hrs		1	Yes 2					
/isic or Atte her dea birecto in by th	Certification:		d not be	f Injury - At h	nome, farm, str	eet, factory	, office t	ouilding, et		or Town S	tate)		Route Number, City
Div pital o	Cert	4 Homicide deter			mily Home	1 No	- 61 al	ete end ni			venue, Baltimor		
Division of ^N To the Hospital or Attending Ph within 24 hours after death. The F Bunear Director. After t completely filled in by the funear.	ical	29a. Certifier 1 Certifying Phone) 2 Medicai Example 1	nysician: To the best o	examination	dge, death occi and/or investig	urred at the ation, in m	y opinior	ate and pro n, death od	curred at the	time, date	and place, and du	a to the ca	ause(s)
To the	Medical	29b. Signature and title of certifie	and manner stat	ed.				se number			29d. Date signed	(Month,	Day, Year)
	14.	Canal A	Helda!				O.C.	M.E.			November 1	6, 2011	
1		30. Name and address of person	who completed cause	of death (Ite	m 23a)	ltimere	Street	Baltim	ore MD 2	1223			
5		24 Data Flori (March Day Your)	sistant Medical E	strar's Signa			Street	, Dailill					
Pegi	State	MIDW 7 U	2011	الم مهد	9. Low	Kel							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 20 36924 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 11:25PM November 14 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death County of Death 501 Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F Country) Maryland **Director** 214-24-9705 82 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must hamonism and the marked of the model. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Baltimore Parkville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21234 U.S.A. 8710 Emge Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed 3 X Widowed 4 Divorced Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sewing Equipment 12 Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Clifton Stallings Francis Hawes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Virginia Avenue, Apt. 110, Towson, MD 21286 Barbara Polasik / Friend imore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Anatomy Gifts Registry 4 X Donation 5 ☐ Other (Specify) 11/16/2011 Hanover, Maryland 21. Signature of Funeral Service Lice see 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ 4 20US Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed Due to (or as a consequence of) 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery vision of Vital Records, P.O. Box 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed y 2 🗌 No 1 Yes 25. Was case referred to prodical 26. Place of Death (Check only one) examiner? Hospital 1 Tes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 Other (Specify) f Death To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director, After th completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated . Signature and title of certifie 086520 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Elkvidio Ma. 21075 6095 Mourshalle 2 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Robert Shauer 2011 16 November Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** andallstown Baltimore Hospice Northwest 7. Age (In yrs. last birthday) If Under Year If Under 24 Hrs. g. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours (Month Director 1 XM 2 □ F 64 28a-f show 10d. Inside City Limits Oa State 10b 10c. City, Town or Location at Director must be notified Paltimoke Windsor 1 🗌 Yes 2 🔀 No MD 10e. Street and Number 10f. Zip Code or 10g. Citizen of What Country? Funeral 23a USA Road Millvale items (13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? Medical Examiner Black White etc ö þ 1 Never Married 2 Married within 72 hours after Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 KNo Specify. 'natural", Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4 or 5+) Pikesville Armor traumatic event, the Guard 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental I Department of Health and Menta Important: If item 27 is marked any injury or other traumation once. ္ဝ Imagene Hundler Rubert N. Shaver, Sr. 19a. Informant's Name/Relationship (Type, 19b. Mailing Address (Street and Number or all Route Number, City or Town, State, Zip Code) -Mill MD 21244 Mother 25 Milluale Road Windsor IMDGene Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 2011 Randallstown, MD 11/19 4 Donation 5 Other (Specify) Mt. Olive United Methodist laughy C. Greene Funeral vervices 21. Signature of Funeral Service Licenses Randallstown MD 21133 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Ca se (Final Physician, Esophageal Cancer disease or con Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) signed by the Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page 2 has death?

1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other Specify no spice 1 Yes 2 No ၀ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending injury 1 Natural

P.O. Box 68760 Division of Vital Records, After this certificate Hospital or Attending Physician: completely filled in by the funeral director, Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No death. Accident Investigation 2 Accident
3 Suicide
4 Homicide 24 hours after death Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the the within To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) è MSRayapalneM.D D0057465 11/18/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 N-S Rajaparse, MID 2835 Smith N 5203 31. Date filed (MNO (18 2011 32. Registrar's Signature State Parks Registrar DHMH 17 Rev 06-2011 ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36926 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ **SPERLING** Month 8000 Bernard 20 M 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shady Grove Adventist Hospital Montgomery Rockville Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 - F (Month, Day eb. 17 . 1936 Washington, DC 577-50-3734 **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location with the Maryland the Medical Examiner must be notified at Director Gaithersburg 1 X Yes 2 □ No MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò Funeral or items 23a U.S.A. 20886 18700 Walkers Choice Rd., #803 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces of t. 1954

1X Yes 2 Navy

Year or Dates. 1 Never Married 2 Married ≥ White Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify "natural", Specify. Completed 3 Widowed 4 Divorced Bernard 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Food Industry Salesman other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Mamie Fox Sperling Jacob 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6289 Tinyon Pine Court, Sykesville, Md. 21784 19a. Informant's Name/Relationship (Type, Print) Department of Health and Inportant: If item 27 is any injury or other trains once Francine Oliver / daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mt. Lebanon Cemetery Nov. 17,2011 Adelphi, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Torchinsky Fiebrew Funeral Homo 21. Signature of Fundral Syrice Licens 20012 254 Carroll St., NW Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardio pulmonary
Due to (or as a consequence of): Physician disease or condition Medical resulting in death) dae Examiner Elevation if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician. The law requires that the death certificate be executed Spirat attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autops has 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending ☐ Accident☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number lt & clearle 71323 20857 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical Color Dr Rockville, MD YENIGHLA USHAKIRAN 31. Date filed (Month Day, Year) State NOV Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 36927 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ November 4:30 PM 2011 CONRAD A. SESSOMS Medical 4c. County of Death Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death **Examiner** Baltimore Washington Medical Center Anne 8. Date of Birth If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 60^{nyrs} 1 XM 2 - F Months Hours 579-68-5797 Director Washington DC 16/195 Usual Residence of Decedent 10b. County 28a-f shor 10a. State 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at Director Crofton 1 X Yes 2 No MD Anne Arundel 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States of America 1932 Paulett Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. **Black** Specify. Completed 3 Widowed AD Divorced permit. Page 1 and 2 should be filed within 72 hours: Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural any injury or other traumatic." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Give kind of work done during most of working life. DO NOT use retired) 12th grade (0-12) College (1-4 or 5+) Professional Driver Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frances Russeau John Ed Sessoms 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3108 Twig Lane Bowie, MD. 20715 Lia Thompson /Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Chesapeake Crematory 11/16/2011 Beltsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign in re of Fune al Service License 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy ST NW WDC 20011 23al Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List odly one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) ancy-undifferentiated Examiner MOYDERI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy ☐ Live Birth ∠ ☐ Folks 300 ☐ Pregnant at time of death ☐ Unknown in the past 12 months? Day Month Year 2 No signed by the a 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Suspected testicular 1 Yes 2 No 3 Probably 4 Unknown 24 hours after death.

• Funeral Director: After this certificate has been si eted filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 잍 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident Investigation Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 24 hor To the Fune completed fi (Check 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DO06815 Sue 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

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Hospital

32. Registrar's Signature

Drive Glen Rurnie

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 12^{Day} 201T 9:18 P M Anna Malinda Settle Nov. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Towson Gilchrist Hospice Center Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8 Date of Birth Birthplace (State or Foreign Country) **Funeral** Days Min (Month, Day, Year) Director 1 M 2 X F 85 188-20-9909 Jan. 9,1926 Pennsylvania 28a-f show 10a. State Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore City MD N/A 1 X Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 United States 5018 Erdman Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2X No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Page 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event the Maximum. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3X Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) Own Home 10 Years <u>Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Virginia Winesickle Henry Fisher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code 21205 5018 Erdman Ave. Baltimore, Maryland Debra A. Eline (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, Baltimore, Maryland Gardens of Faith Cem. 11/16/2011 4 Donation 5 Other (Specify) Signature Funeral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
2022 Wise Ave Dundalk, Maryland 21222 7922 Wise Ave. Dundalk, Maryland sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, are List only one cause on each line. 23a. Part 1. Enter the shock, or heart/ Interval Between Immediate Cause (F Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death igned by the a be detached f g Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 ► No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pendina Accident after death. 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 7104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FUMA 6701 ST SULTE 7105 State NOV 1

DHMH 17 Rev 06-2011

Registrar

11-08495 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene William Bennie Strong 1. For State Certificate of Death Registrar 2 Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ William Bennie Strong
Strong Month Day November 12, 2011 0156 hrs Medical Examiner Willian Pennie 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Havre de Grace Harford 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Director Country) MD 219.44.6843 09.26.1946 1 3M 2 F 65 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location IDY 1 Yes 2 No 28a-f show MD Harford Havre-De-Grace , nr items 23a or 28a-f shor 21215-0036
ould be filed within 72 hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe 525 Craigs Corner Road 21078 U.S.A. 14. Race - American Indian, Black 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status event, the Medical Examiner must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 Married Yes 1 Yes 2 No specify: 3 Widowed 4 Divorced If Yes, Give Year SpecWhite bernit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene.
important: If item 27 is marked nther than "natural", <u>る</u> 16a, Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Grocery Cutter 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William B. Strong,

19a. Informant's Name/Relationship (Type, Print) Palmer Arietta 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21078 ter 102 BAyland Dr 20b. Place of Disposition (Name of cemetery, Elizabeth Noonkester/sister Unit Havre-De-Crace
20c. Location - City or Town, State 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Chesapeake Crem. 11.17.11 Beltsville, MD 4 Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licensee CAFA/Stephen D. Lohrmann, PA MO 1443 Pastures Dr Green Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and **IMedica** Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Hypertensive Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to for as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical the attending physician a X UNPENDED X AMENDED #1,4a,23a,ptI,II,27perME,G921,11/29/2011,WS Records, P.O. Box 68760, 23d Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 虿 1 Yes 2 No 3 Probably 4 Unknown Chronic Cocaine Use Completed page 2 should 24a, Was an 24b. Were autopsy findings available After this certificate has been prior to completion of cause of death? autopsy performed' 1 🗸 Yes ✓ Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Hospital or Attending Physician: funeral director, Division of Vital examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other: Scene 1 🗸 Yes 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death 1 X Natural 1 Yes 2 No I Director: ed in by the f 5 Pending within 24 hours after death.

To the Funeral Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) determined Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 W Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E. November 12, 2011 30. Name and address of person who completed cause of death (Item 23a) Ana Rubio MD Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registra s Signat State NUV 18 2011

DHMH 17 Rev 1/2001 OCME 2006

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 15 Mary L. Sommerville Physician/ NOV -2011 8:10a Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner Baltimore Towson Gilchrist Center Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) If Under 7. Age (In vrs. last birthday) **Funeral** Hours 235-22-2915 Director 1 M 2 SXF March22,1925 WVA 86 Yrs Usual Residence of Decedent or 28a-f show e notified at 10d. Inside City Limits 10a. State 10c. City. Town or Location filed within 72 hours after death with the Maryland Director MD Baltimore Essex 1 Yes 2 No 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe must be USA 23a Funeral 21221 4 Eugene Avenue items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status than "natural", or iter he Medical Examiner Black, White, etc. or þ 1 Yes 25
If Yes, Give
Year or Dates. 1 Never Married 2 Married 2**X** No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 XWidowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) alth and Mental Hygiene.

27 is marked other than r traumatic event, the Ms Flementary/Secondary (0-12) College (1-4 or 5+) own home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ruth Oster permit. Page 1 and 2 should be f Department of Health and Menta Rex Kelley 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 Eugene Avenue Baltimore MD 21221 /daughter Cyntha Adams 27 item 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Important: If it any injury or o once. 1 🗌 Burial 2 🕱 Cremation 3 🗌 Removal from State Bayview Crematory 11/16/11 Baltimore MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or Interval Between Onset and Death shock or heart failure. List of Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Examiner Sequentiary list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed tran and that initiated events Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE: nse s 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy for Month Day in the past 12 Pregnant at time of death ed by the a 2 No Unknown 9 Unknown th but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant cor Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? has page certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral o

State

Medical

4 Homicide

29a. Certifier (Chec

determined

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

BRILOOG

29d. Date signed (Month, Day, Year)

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Name and address of person who completed cause of death (Item 23a) (Type Print). Suite 4105, Balthware, MD & 1204

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Tay 15 Physician/ Month 2011 4:50 pM Jeanne Dieffenbach Smith Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Carroll Carroll Lutheran Village Westminster 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex . Age (In vrs. last birthday) **Funeral** May 21,1922 Min Waryland 1 □ M 2 🔽 F 89 217-20-7705 Yrs **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County with the Maryland Director r 28a-f sh notified 1 Yes 2 No Maryland Westminster Carroll 10g. Citizen of What Country? 10e. Street and Number items 23a or ner must be Funeral 316 21158 U.S.A. 205 St. Mark Way Apt. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status er than "natural", or ite the Medical Examiner Armed Forces?
1 ☐ Yes 2 ☒ No Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White Completed 3 Widowed 4 Divorced 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) of Social Services State of Maryland is marked other Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Madeleine Louise Gilbert Otto W. Dieffenbach 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21158 19a. Informant's Name/Relationship (Type, Print) 27 Benjamin G. Smith - husband 205 St. Mark Way, Apt. 316, Westminster, MD Department of Healt Important: If item 2 any injury or other once. injury or other Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State All Faiths Crematory Nov. 18 ,2011 Manchester, 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityEckhardt Funeral Chapel P.A. 21102 3296 Manchester, Charmil Dr. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Mertusewt Medical resulting in death) Due to (or as a consequence of) Examiner Comor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Other (specify) Pregnant at time of death signed by the aid 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 3 Probably 4 Unknown 1 Yes Completed should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an his certificate has bal director, page 2 sh autopsy performe 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident n 24 hours after death le Funeral Director: A bleted filled in by the f Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined edical wledge, death occured to time, date and place, and due to the cause(s) and manner as stated.

nation and/or investigation, i... y opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 1 Certifying Physician: e best of my of Medical Examiner: on the basis of e in a Gertifying Nursy ractioner: To typest (Check ination and/or investicurred at the time, date and place, and due to the cause(s) and manner as stated. est of my knowle only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 23a) (Type, **9** Name and address of person w Alexander Month, Day, Beoglaschews

✓ DHMH 17 Rev 7/2009

State Registrar

JEANNE

32. Registrar's Sign

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical Nov. 16 Day 201 6:58pM Wilbur Newell Sargent 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Hospice Dove House Carroll Westminster 9. Birthplace (State or Foreign Country) Ohio If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day Nov 1 Social Security Number 7. Age (In yrs. last birthday, **Funeral** 1 XM 2 □ Director 214-24-5373 83 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Marylan¢ Carroll Manchester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21102 U.S.A. 2601 Fridinger Mill Rd. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Yes 2 No 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", or þ Saltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last, Vernal Sargent Agnes Fletcher permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Bruce Sargent – son 2601 Fridinger Mill Rd. Manchester, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) NOV. 20a. Method of Disposition 20c. Location - City or Town, State 18,201 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Faiths Crematory Manchester, 22. Name and Address of Facility Eckhardt Funeral Chapel P.A. 21. Signature of Funeral Service Licensee Hall allelo 3296 Charmil Dr. Manchester, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immedicause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be defached for use as the burn completed filled in by the funeral director, page 2 should be defached for use as the burn. Division of Vital Records, P.O. Box 68760 IF FEMALE: Live Birth 2 Fetal death yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnap 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Month Day 2 1100 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 I hoknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed 1 Yes 2 1 Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 2 4No 1 Inpatient 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred HOWE Certificate: Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Investigation Could not be Accident Suicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29d. Date signed (Month. Dav. Year) completed cause of death (Item 23a) (Type, Print)

State Registrar

B. Kanena

32. Registrar's Signatur

Malcalm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36933 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Month Physician/ Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A BALTIMORE 100 LARUE SQUARE NORTH If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday. Date of Birth **Funeral** (Month, Dav. Year) 219-28-0029 Director 1 □ M 2 🗓 F Yrs 10-30-1935 MARYLAND 76 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State must be notified at Director 1 Xes 2 No N/A BALTIMORE MD. 10f. Zip Code 10g, Citizen of What Country? ò 10e. Street and Number Funeral items 23a USA 100 LARUE SQUARE NORTH 21225 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Ь þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examin once. 3altimore, Maryland 21215-0036 1 Yes 2 No Specify If Yes, Give Year or Dates Completed 3 X Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) -12--0-NURSE HEALTHCARE Be 17. Father's Name (First, Middle, Last) UNKNOWN 18. Mother's Name (First, Middle, Maiden Surname) 0 ELIZABETH D. PETTIFORD 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BALTIMORE MARYLAND 21225 400 SWALE AVE. RONALD SAUNDERS, SR(SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of D 20c. Location - City or Town, State sposition Date 1 XBurial 2 X Cremation 3 Removal from State BALTIMORE, MARYLAND WOODLAWN CEMETERY 11-17-2011 4 Donation 5 Other (Specify) JONATHAN D. HIBNER 2. Name and Address of Facility REDD FUNERAL SERVICE 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner but to (or ен в полнециятел of) Due to (or as a consequence of) resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3

Ectopic pregnancy in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?1 ☐ Yes 2 ☐ No 24a. Was an autopsy has Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be Other: 4 \(\text{Nursing Home} \) Residence 6 \(\text{Other} \) Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural 2 Accident 5 Pending work? 2 🗌 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 06-2011

State

30. Name and address of

Date filed (Month, Day, Year)

NOV 1

ompleted cause of death (Item 22)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Jeffrey Nelson Stou	t 1- For State Registrar	S	tate of Maryland	Departm/ <i>Certific</i>			Mental I		g. No. 2	011	3693
Physician/	1. Decedent's N	lame (First, Mide						2. Date of Death Month November			ime of Death
Medical Examiner		Nelsor	Stout on, give street and number)			b. City, Town, or Le	ocation of Dea		15, 2011 4c. County of		1339 1118
		Oak Road	on, give street and number /			Baltimore			Baltimore	County	
Funeral Director	5. Social Secur 215-92	-2962	6. Sex 7. Ag 1	e (In yrs. last bi 47	rthday) Yrs.	If Under 1 Year Months Days		Irs. 8. Date of Birth lin. NOV • 24		Foreign	ce (State or Maryland
way	Usual Residend	e of Decedent 10b. County		10c. City, Tow	n or Location	on					I. Inside City Limits
Maryland 28a-f show any d at once rector	MD	Balti	more	Baltim	ore						Yes 2 X No
the Maryland a or 28a-f sh fiffied at one	10e. Street and		•			10f. Zip Code		i	g. Citizen of Wha	it Country?	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 37 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	906 OL	d Oak Ro	12 Was Decedent	Ever in U.S.				Specify Yes or No-			Indian, Black,
er death with t , or items 23s r must be not Funeral	1 Never N	larried 2h	1 Yes 2	X No	If Ye	es, specify Cuban,	Mexican, Pue	rto Rican, etc.)	White,		
s after rail", o	45 December		vorced If Yes, Give Yaar or Dates: ecify only highest grade con			Yes 2X No		of work done	Specify: 16b. Kind of Bus	whit	
2 hour "natu	Elementary/	Secondary (0-12				st of working life. [100. 14114 07 240		,
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exan	12		4	Ir	nforma	ation Tec			T. Rowe		е
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	17. Father's Na	me (First, Middle) $Nelson~S$	•					me (First, Middle, M Niemeyer	alden Surname)		
212 ould be d Ment a mark tie ever			ship (Type, Print)		_	Address (Street	and Number of	or Rural Route Num		, State, Zip	Code)
MD and 2 sho alth and 2 th and 27 to raumati	Judith	A. Sto	it / mothe			ormand Ro		ındalk, MI	20c. Location - 0	City or Tow	n, State
Baltimore, permit. Pages 1 ar Department of He. Important: If ite Important: of the injury or other training or other tr	1 Burial	2 X Crematic	on 3 Removal from St	ate crema	atory or oth	er place)		./18/2011			
nit. Pa artmen ortant		n 5 Other 3		Lurrr		ame and Address		./ 10/ 2011	10005011		ork Road
	/4	Str. Cl	ley					al Home,			, MD 21204
Physician // Medicar	23a. Part I. Ent failure. Lis	er the disease, on tonly one caus						c or respiratory arre	st, snock, or nea	" P	letween Onset and Death
Examiner		ise (Final diseas sulting in death)	e a. Complicat Due to (or as a cons		live	r Diseas	e			\rightarrow	
-	Sequentially list		b. Due to (or as a cons	edilence of):							
mine	cause. Enter (Inderlying Caus ury that initiated	9 с							_	
d ansit	events resultin	g in death) Last	Due to (or as a cons	equence of):					_		
50, be executed ysician and burial - transit	X UNPEN	DED	☐ AMENDED 23a	,27,per	me,g	921 11-2	2-11 s	m		.,	
		dent pregnant in	the 23c. If yes, outcome 1 Live birth	me of pregnanc		aldeath 3	Ectopic pre	anancy	23d. Date of o	delivery Day	Year
. Box 6876(the death certificate the death certificate y the attending phy ched for use as the Physician/Me	past 12 mg		4 Pregnant at	time of death	- =	ner (Specify)			ļ.		
- e + e -	Part II. Other		1tions contributing to deat	h but not result	ing in the u	nderlying cause gi	iven in Part I.	23e, Did to	bacco use contrit	bute to the	cause of death?
Vital Records, P.O. B system: The law requires that the d his certificate has been signed by the director, page 2 should be detached o Be Completed by Phy		=					<u></u>	1 Yes	2 No 3	Probably	y 4 🗹 Unknown
ords, v requires should								24a. Was a	sy p	rior to comp	by findings available bletion of cause of
Records, The law requires ficate has been sig								perfor 1 ✓ Yes		eath? ✔ Yes	2 No
ician: icertifi rector,	25. Was case examiner?	referred to medic	The solids -	ent 2 ER/	Outpatient		of Death (Che Other ไ	ck only one)	Residence 6	Other: Sc	ene
	27 Manner of	2 No	28a. Date of Inj (Month, Day,		. Time of Ir		y at Work?		now injury occurre		
ion (teodin eath. A the fur	1 X Natura	→ Fe	nding estigation				es 2 No				
돌 등 설립 등 (등	3 Suicide	6 Co	uld not be ermined (Specify)	njury - At home,	farm, stree	t, factory, office bu	uilding, etc.	28f. Location (S or Town, S		r or Rural F	Route Number, City
C File bound		Certifying	Physician: To the best of m	ny knowledge, o	leath occur	red at the time, dat	te and place,	and due to the caus	e(s) and manner	as stated.	
To the Hos within 24 h To the Fur completely	one) 2		caminer:On the basis of exa and manner stated	mination and/o	r investigat			ed at the time, date			
A STATE OF	29b. Signature	and title of certi	fier / On A A			29c. License			29d. Date signe November		
	30. Name and	address of person	on who completed cause of	death (Item 23a)						
Keed	Carol Al		ssistant Medical Exa			imore Street,	Baltimore,	MD 21223		<u></u>	
State Registra		Month, Day, Yea		ar's Signature	has	Val.					
DHMH 17 Rev 1/2001		INUN J. (1.6011-1/2/200	· /c/·	RIGINA						

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36935 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 5 Physician/ 2011 11:11 PM Sohn November Buyong Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numbe 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Months 147-74-4061 **Director** 1 🗆 M 2 💢 F 62 1949 Korea Sept 22, Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Parkville 1 Yes 2 X No MD. Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral with Korea 21234 6 Revere Court Apt. E hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. should be filed within 72 hours after cand Mental Hygiene.
is marked other than "natural", or 9 1 Never Married 2 X Married Yes 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Korean If Yes. Give Specify: 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Artist permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Bok Duk Park Young Ki Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Revere Court Apt. E Parkville, MD. 21234 Inkun Sohn/ Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 11-19-11 Timonium, MD. Dulanev Vallev Mem. 21. Signature of Ineral Service Lig 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson. MD. 23a. Part 1. Enter the disease or commiscations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ morro disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed Cause (Disease or injury y physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 use as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Year Day Pregnant at time of death the P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Division of Vital Records, 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 X No this certificate 1 🗌 Yes 2 🗌 No 25. Was case referred to medical director. Be 26. Place of Death (Check only one, examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Tes 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Deat Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completely filled in by the funer 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated title of certifier 29b. Signature 29d. Date signed (Month, Day, Year, November 16 2011 30. Name and add pleted cause of death (Item 23a) (Type, Print) Charles ST TONSONME

DHMH 17 Rev 06-2011

State

Registrar

8

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		For State	Plea	se Type or Pr State of M		d / Depa		Health and		/giene	001	. 2	c n 2 (
Physici /Medi		Registrar 1. Decedent's Name Sakire	(First, Middle,	Last)		Ta	nriove	· X	2. Date of D Month Wovembe	Da	Year 2011	3. Time	of Death
Examir		4a. Facility Name (If The Johns 5. Social Security No.	Hopkins	Sev 7 A	ge (În yrs. la	ıst birthday)	Baltimore	If Under 24 H	rs. 8. Date of B	rth		rthplace (State	or Foreign
Director		213-06-1 Usual Residence of 10a. State		1 □ M 2 □ F	56	Yrs.	Months Days	Hours Min	Jan 2	7, 1		irkey 10d. Inside	
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1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Health and Mental Hygiene. em 27 is marked other than "natural", or items 23a or 28a-f show wither traumatic event, the Medical Examiner must be notified at	þ	2306 Val. 11. Marital Status 1 □ Never Marrie 3 □ Widowed	ed 2 🙀 Marrie	12. Was Decedent Armed Forces			2060 Vas Decedent of H Yes, specify Cub	Hispanic Origin? an, Mexican, Pue	(Specify Yes or Norto Rican, etc.)	0-	14. Race - Am Black, Whi		
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v requires that the de been signed by the a should be detached	ted by Phys	Part II. Other signifi	icant condition	ns contributing to death	but not resu	ulting in the u	nderlying cause (given in Part I.			use contribute 2 X No 3 □ I	to the cause or	
The law ate has b page 2 s	Completed	25. Was case referre	ad to medical					26 Place of D		opsy formed? 2 N	prior to death		gs available of cause of
Sop	ation: To Be	examiner? 1 Yes 2 1 27. Manner of Death 1 Natural 2 Accident	No	Hospital: 1 Inpat 28a. Date of Inj (Month, Date)	ury	ER/Outpatien 28b. Time o Injury	28c. Inju	her: 4 \(\sum \) Nursing	Home 5 Res	sidence		ecify)	
i \$ if 6	l Certification:	3 ☐ Suicide 4 ☐ Homicide 29a. Certifier	6 Could no determin	200. 1 1000 01 111	tc. (Specify))	eet, factory, office	ime, date and pla	City or To	own, State			lumber,
To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(check only one) 29b. Signature and	2 Medical E	xaminer: On the basis and manner s	of examinati			opinion, death of		e, date a		lue to the caus	
4		JIL	m Ca	who completed cause of	death (Item	1 23a) (Type,	Print)	<u>S-UU</u>	0 North W	olfe S	espey St, Baltim	ore, MC), 21287
Sta Regist		31. Date filed (Monta			rar's Signati	fear	les !						

DHMH 17 Rev 1/2001

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			State of Maryland / I	•			d Mental F	lygier	e				
	7-State Amend 6 per b.c. g921 11/18 Centificate of Death 1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last)												
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	Medic Examin		4a. Facility Name (if not institution, give street and number)		o. City, Town, or L	ocation of De			c. County of De				
			Shadu Grove Adventist Hosp	Pitof	Roc	levill.	2		mont	onery			
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt.		Under 1 Year onths Days	If Under 24 H Hours M		Birth Day, Year	9. E	Sirthplace (State or Foreign Country)			
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	and show	tor	10a. State 10b. County 10c. City, Town	n or Locatic	on					10d. Inside City Limits			
	Maryi 28a-f otifie	Director	MD Montgomery Ro	ockvil	11e					1 ☐ Yes 2 🖾 No			
	h the	al D	10e. Street and Number	1	10f. Zip Code	850		10g.	Citizen of What C	Country?			
	be filed within 72 hours after death with the Maryland ental Hygiene. Ked other than "natural", or items 23a or 28a-f show te event, the Medical Examiner must be notified at	Funeral	455 Elm Croft Blvd 11. Marital Status 12. Was Decedent Ever in U.S.	10 Wee	Decedent of Hist		(Specify Vos or I	lo-	T	and the Ladian			
0	er dea or ite niner	by Fi	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces 1 Married 1 Yes 2 No	If Yes	s, specify Cuban,	Mexican, Pu	uerto Rican, etc.)	40-	Black, Wh	nerican Indian, nite, etc.			
21215-0036	ırs aft ural", IExal	ed k	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates.	1 🗆	Yes 2 No	Specify:			Specify:	olack			
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ק ק	filed w al Hygi d other went, i	æ	17. Father's Name (First, Middle, Last)				Name (First, Mide						
<u>Jar</u>	d be f Venta arked	유	Jason Todd				Christin	e To	1d 				
, Maryland	d 2 should be alth and Men 27 is marke er traumatic		19a. Informant's Name/Relationship (Type, Print) 19b Shady Grove Adventist Hospital 19b	o. Mailing Ad 9901 1	^{ddress} (Street an Medical	^{d Number} or Center	Rural Route Num r Drive	ber, City Rock	or Town, State, Ville, N	20850			
Baltimore,	Page 1 and 2 nent of Healt ant: If item 2 ury or other		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) in state	of Disposition ery, cremato	on (Name of ary or other place)		Date	20c.	Location - City	or Town, State			
Balti	permit. Page Department of Important: If any injury or once,		21. Signature Ferneral Service Con Director		me and Address Ite Anat Itimore,	-		W. I	Balt i mor	e Street			
			23a. Part 1 Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.					arrest,		Approximate Interval Between			
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3	cate b physic the b	edical	d. Cervical	エハ	comp	erca							
200	certific nding use as	N/M	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy						23d. Date of	delivery			
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<u>=</u>	ian: T rtifica rtor, p	Be C	25. Was case referred to medical examiner?		26. Plac	e of Death (C	Check only one)	28 201	100	ies z ONO			
Ĭ	hysic his ce il direc	70	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Ou		DOA Other:	4 🗆 Nursin	ng Home 5 □ R	esidence	6 ☐ Other (Sp	ecify)			
DIVISION OF VITAL RECORDS,	ending P sath. or: After t he funera	Certificate:	1 Natural 5 Pending (Month, Day, Year) is 2 Accident Investigation	Time of injury	28c. Injury a work? M 1 🗆 Ye	at es 2□No		e how inj	ury occurred				
DIVISI	tal or Att		3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	ırm, street, f	factory, office			n <i>(Str</i> eet a Town, Sta		Rural Route Number,			
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check (Check only one) 1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/o	or investigati	ion, in my opinion,	death occurr	red at the time, da	te and pla	ce, and due to th	e cause(s) and manner stated.			
_	Note that the control of the control		29b. Signature and title of certifier		29c. License r		2		Date signed (Moi				
)			30. Name and address of person who completed cause of death (Item 23a) (Ø 2	D 4	062	- 1	120	venbe	23,2011			
			the Ton 9715 medica	1 Cd	r Dr	4330	Roc	levi.	lle Mi	20150			
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	arked									

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			_ For	State of	Maryland	d / Depa	artment of	Health an	d Mental H	ygiene		
			State Registrar			Cer	tificate of	Death		Reg. No. 2	11	36938
	Physicia	ın/	1. Decedent's Name (First, Middle, Las Miriam S		ongue				2. Date of D Month Novemb		2011	3. Time of Death 12:25 PM
	Medic Examir		4a. Facility Name (if not institution, give				4b City Town	or Location of D			ty of Death	
-	Examir	ier	Pear Tree Assiste		,	ities	, ,	asadena				rundel
	Funeral		5. Social Security Number 6. S	ex 7.	Age (In yrs. la	st birthday)	If Under 1 Yea Months Days		Hrs. 8. Date of B		9. Birth	place (State or Foreign
	Director			□ M 2 🗓 F	(94 Yrs.	I Day	, I riodio	(**************************************	L6 1917		MD
	nd how at	=	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Lo	cation				1	10d. Inside City Limits
	faryla Ba-f s tified	Director	Maryland Anne	Arundel			I	asadena				1 🗌 Yes 2 🗓 No
	the N a or 2 se no		10e. Street and Number				10f. Zip Code			10g. Citizen of	What Cour	ntry?
	h with	Funeral	450 Edgewater Ro	ad				21122		<u> </u>	USA	
920	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	s? █ No		Vas Decedent of f Yes, specify Cul	oan, Mexican, Pu	(Specify Yes or No uerto Rican, etc.)		ice - Americ ack, White, fy: W	
21215-0036	72 hour n "natu ledical	Completed	15. Decedent's E (Specify only highest gr	ade completed)		(Give	lent's Usual Occi kind of work done O NOT use retire	during most of	working	16b. Kind of I	3usiness/In	idustry
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ylaı	ld be Menta arked atic e	ြင	James Phillip	s Stro	ng			Carr	rie C	onner		
Maryland	shou and is m raum		19a. Informant's Name/Relationship (7			1	,		Rural Route Numb			Code)
	and 2 Health em 2: ther t		Carolyn Wisthoff 20a. Method of Disposition	(daught			Edgewat	er Road,	Pasaden Date	a, MD 21		own State
nor	age 1 ant of It: If it		1 X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		ate C	emetery, crer	natory or other pi Epis Cem		ov. 15 2011		,	e, Maryland
Baltimore,	permit. Po Departme Importar any injur		21. Signature of Funeral Service Licen	_			. Name and Add	ress of Facility		llings F	unera	al Home, P.A
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only t	plications, hat cau	sed the death	n. Do not ente					IND 2	Approximate
- 46	Ph_sician/		shock, or heart failure. List only to immediate Cause (Final disease or condition	ne cause on ca	line.	ر م اف	him					Interval Between Onset and Death
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09	ate be executed physician and the burial-transit	dical		d								
9289	ificate ig phy as th	Med	IF FEMALE:									
Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transi	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 5 No	4 Pregna	th 2 🗌 Feta nt at time of d	I death 3	Ectopic pregna Other (specify)				Date of deliv	very Day Year
P.O. E	es that the dea signed by the a I be detached I	Phys	9 Unknown Part II. Other significant conditions of	9 Unknov		ulting in the	anderlying course	given in Bort I	OO - Die	14-5	atributa ta :	the cause of death?
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alF	sician: The certificate irector, pag	Be C	25. Was case referred to medical examiner?				26.	Place of Death (Λ.		. 1
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υof	ling P n. After t funera	ate:	27. Manner of Deat 1 Natural 5 Pending		injury Day, Year)	28b. Time of injury	w	uryat ork? ∐Yes 2 □ No		e how injury occu	rred	`
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Division of Vital Records,	al or A safter I Direct		4 Homicide determined	building	, etc. (Specify)	eet, factory, offic		City or T	own, State)		
_	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral	Medical	29a. Certifier 1 Certifying Phy (Check Medical Exam	sician: To the bes	t of my knowl	edge, death	occurred at the ti	me, date and pla	ace, and due to the	cause(s) and ma	nner as sta	ated. ause(s) and manner stated
	thin 2, the F the F mplet	Me	only one 3 Certifying Nur	se Practitioner: T	o the best of n	ny knowledge	, death occurred a	at the time, date a	and place, and due t	o the cause(s) and	manner as	s stated.
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	•		ou. Name and address of person who	completed cause	of death (Itom	234 (T/A)	rint)	1 7	D. N	0.	1	Mish
			werge kere		1);	7400	MOLIN	マキア	NOgic	Tasa	CIM	4 My m
	Sta Registr		31. Date filed (Month, Day, Year)	32. Reg	Istrar's Signat	back	1					/ 1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death WOIR Physician/ ahe rmat Month 8:00 A 14) Medical 2011 **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospila enter Westminste long 6. Sex 8. Date of Birth (Month, Pay, Nov 14, Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 1 🗆 M 2 🗓 F Months Days Hours Min Maryland 1927 **Director** 212-24-3339 84 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Carroll Westminster 1 Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21 Timber Ridge Dr. 21157 USA 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Completed by ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 white 1 Yes 2 X No 3 Midowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed nould be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) nursing assistant healthcare Be 17. Father's Name (First, Middle, Last) Should be file and Mental F. 18. Mother's Name (First, Middle, Maiden Surname) ည Bessie Rosella Kelly John Oden Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh
Department of Health ar
Important: If item 27 is
any injury or other trau Theresa Howard - granddaughter 4120 Upper Beckleysville Rd; Hampstead, MD 21074 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donator Donator (Specify) 21. Signate of Funeral Se 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock. or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examine Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnan 23d. Date of delivery Live Birth 2 Fetal death Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month been signed by the should be detached 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, Completed 1 Yes 2 No 3 Probably 4 Unknown obrillation 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law page 2 s has autopsy death? this certificate 2 No Division of Vital the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 \(\sum_{\text{Nursing Home}}\) Nursing Home 5 \(\sum_{\text{Residence}}\) Residence 6 \(\sum_{\text{Other}}\) Other (Specify) 1 Yes 2 🗹 No ျှ Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 27. Manyer of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of To the Hospital or Attending F within 24 hours after death.
To the Funeral Director: After 28d. Describe how injury occurred Natural 5 Pending 1 Yes Accident Investigation 6 Could not be 2 No Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jov. 201 Medical 4a. Facility Name (if not institution, give street and number **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Alice Manor Nursing Home Baltimore n/a Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Months Hours (Month, Day, Yea 5-9-1927 Country) **Director** 218–22–1672 Usual Residence of Decedent 1 □ M 2 🂢 F MD 84 Yrs ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🔯 No Baltimore Gwynn Oak MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3412 Keston Road 21207 USA Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: African-American "natural" Completed 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) <u>Baltimore County Schools</u> Cook Be (17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) n and Mental F မ Herbert Carey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau James Wainwright/ Husband 3412 Keston Road, Gwynn Oak, MD 21207 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ▼ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) King Memorial Park 11-19-2011 Woodlawn, MD Wylie Funeral Home P.A. of Haltimore Co. 22. Name and Address of Facility Signature 9200 Liberty Road, Randallstown, MD 21133 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) Medical **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause, Enter Underlying Cause (Disease or injury Due to (or as a consequence the attending physician and ched for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) Live Birth 2 Fetal death in the past 12 months? Month Year Dav Pregnant at time of death page 2 should be detached 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autop-performed death? 2 1 NO After this certificate Yes completely filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) Manner Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident nvestigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 06-2011

State Registrar Deneu

82. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Lewis Allen Wood, Jr. November P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 11500 Metronome Court Prince George's Clinton 5. Social Security Number If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Days Hours Min July 9, 1941 Months 579-56-3711 Virginia 70 Director Usual Residence of Decedent 28a-f show 10b. County with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Prince George's Clinton 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11500 Metronome Court 20735 **IISA** permit. Page 1 and 2 should be filed within 72 hours after death v. Department of Health and Mental Hygiene. Important: If item 27 is marked other any injury or other constants. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1X Yes 2 No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 2 1 Never Married 2 Married 1 Yes 2 No Specify If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Gov't. Printing Office Printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Lewis Allen Wood Sr. Fairfax Wood 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard A. Wood 3429 North Dyer Flagstaff, AZ 86004 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place) Cedar Hill Cemetery 11-21-11 4 Donation 5 Other (Specify) Suitland, MD Bell Funeral Home 21. Signature of Funeral Service Lig 22. Name and Address of Facility Charlottesville, VA 22903 108 6th St. NW Part 1.1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hypertension disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner gly comic Sequentially list conditions Examine Due t cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed USR 000000 that initiated events resulting in death) Last Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a a Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 X Yes 2 No 3 Probably 4 Unknown should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an page 2 s autopsy performed Yes 2 certificate 2 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 🕅 No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred injury 1 🛚 Natural 5 Pending 2 🗌 No 1 Yes Investigation Accident after death filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral I Medical 1 💹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Function

completed 1 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one

State Registrar 29b. Signature and title of certifie

uchech 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

5801 Allentown Road #510 Camp Springs, MD

back

29d. Date signed (Month, Day, Year)

20746

11-08616 Sha

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

aron Whalen		1- For State Registrar	State of Maryland /		ent of He ate of De			Reg. No.	201	1 369	4
Physici dical Exami	an/		die,Last) Ann			Whalen	2. Date of De Month Novemb	Day er 16, 201	Year	3. Time of Death 1210 hrs	
		4a. Facility Name (if not institute 712 West 34th Street				y, Town, or Location		-	unty of Death		
Funeral		5. Social Security Number	6. Sex 7. Age	(In yrs. last birt	thday) If L			Birth (MM/DD/)	(YYY) 9. Birth Foreign	nplace (State or	
Director		410-84-5202 Usual Residence of Decedent	1 M 2 X F	64	Yrs.		rs Min. 10/01/	/194/	Cou	intry) TN	
d how any		10a. State 10b. County MD N/A	y 1	Oc. City, Town Baltimor						10d. Inside City Limit	
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland calth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f show fraumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 712 W. 34th St.				Zip Code		10g. Citizen o	of What Coun	try?	
th with th tems 23a	uneral [11. Marital Status 1 Never Married 2	12. Was Decedent E Married Armed Forces?	ver in U.S.	13. Was Dec	edent of Hispanic Or	rigin? (Specify Yes or N n, Puerto Rican, etc.)		Race - Americ White, etc.	an Indian, Black,	
after dea	by Fur	3 Widowed 4 XD	1 Yes 2 ivorced If Yes, Give Year or Dates:	No		2X No specif		Spe		White	
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OO36 within giene.	Completed	12 17. Father's Name (First, Middl	4	Sun	mer Jobs	Coordinato	er's Name (First, Middle		imore Ci	ty	_
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", ite Medical Examines	Be	Thomas	Hardy		Whal	en Just	tine	Iona		Stricklan	ıd
MD 2 12 shoule th and M a 27 is m	10	19a. Informant's Name/Relation Conan Whalen-McC					umber or Rural Route No Baltimore, MD		Town, State,	Zip Code)	
iore, lages I and nt of Heal t: If item other tra			on 3 Removal from State	cremat	of Disposition (tory or other pla D SVC. (Date 11/18/2011		tion - City or 1 on, Mary		
Baltimore, permit. Pages 1 an Department of Hee Important: If ite		21. Signature of Funeral Service		111110	22. Name a	and Address of Facil	ity Leonard J.	Ruck.	Inc.	Tark.	_
Physician		23a. Part I. Enter the disease, of	or complications that caused th	ne death. Do no			d, Baltimore, cardiac or respiratory a			Approximate Interv	
/Medical Examiner		failure. List only one caus Immediate Cause (Final diseas or condition resulting in death)	Ob!- Alb-!!		rhosis of the	Liver				Between Onset an Death	iq
7	<u>_</u>	Sequentially list conditions, if any, leading to immediate	b								_
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Division tal or Attendiu rs after death. al Director: A led in by the fu	Icatio	2 Accident Inv	nding estigation 28e Place of Inju		arm, street, fact	1 Yes 2 ory, office building,		(Street and N	lumber or Rur	al Route Number, Ci	ity
DIVI ospital or hours afte meral Div	Certificati	4 Homicide det	uld not be ermined (Specify)				or Town,				_
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10 4		30. Name and address of person			000111		Dalain		·		
St	ate	Russell Alexander M 31. Date filed (Month, Cay, Year	D. Assistant Medica 32. Registracts		900 W. E	saitimore Street	, Baltimore, MD 2	1223			
Regis		NUV 1	& 2011 Receive	1	barke	1		GME			_
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month P: ODAM Mar. 0// Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death CLRC 6. Sex If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 □ F Months Hours Min. (Month, Day, Country) **Director** 238-98-8452 Usual Residence of Decedent or items 23a or 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at Director Baltimore 1 Xes 2 No MD NA 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 U.S.A. 529 North Belnord Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces? 1 X Never Married 2 Married þ 1 Yes : 2 🗌 No Maryland 21215-0036 1 ☐ Yes 🌠 No Specify. 3 ☐ Widowed 4 ☐ Divorced Specify: "natural" Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) VA Hospital Enviornmental Services 12th grade na Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rovella Fairmaire Davis Willie L. Watson Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7869 New Freetown Road, Pasadena, Md 21122 19a. Informant's Name/Relationship (Type, Print) Lillian Wilburn-Sister Page 1 and 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1. Burial 2 Cremation 3 Removal from State
4 Donation 5 Other (Specify) Crownsville Vet. 11/21/2011 Crownsville, 21. Signature of Fundal Service Licens 22. Name and Address of Facility
March F H West
4300 Wabash Ave, 21215 Baltimore, 23a. Part 1. Egyer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading in a delicause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of the Hospital or Attending Physician: The law requires that the death certificate be executed oertificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-tran the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 2 Inpa within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No 1 X Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 29a Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of sertifier 29c. License number

DHMH 17 Rev 7/2009

State

Registrar

3900

31. Date filed (Month, Day, Year)-

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36944 Certificate of Death Reg. No. 2 [] 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:25 pm NOVEMBER 15 JOSEPH M. WHITE 2011 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death N/A O VERLEA HEALTH AND REIMAG CENTER BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month Day Year) 5. Social Security Number Sex 11 M 2□F 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Hours Min. Months Days WASHINGTON DC 218-26-9818 81 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 LayYes 2 La No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 5501 BELAIR RD APT 5 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify Specify: BLACK 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) -10-INSTALLER AUTO 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JOHN W. WHITE REGINA HEWLETT 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HILDA THOMAS (DAUGHTER) 5501 BELAIR RD. APT 5 BALTIMORE, MARYLAND 21206 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial / XX ren ation 3 ☐ Removal from State 11-22-2011 METRO CREMATORY BALTIMORE, MARYLAND 5 ☐ ther (Specify) 4 Donation Funeral Service Licensee JONATHAN D. HIBNER Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 23a. Parv1. Inter the disease, or complications that caused the death. shick, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate ause (Final disease of condition resulting in death) LUNG Due to (or as a consequence of): Sequentially list conditions, Due to (or as a nunsequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

5

items 23a

'natural", or

Department of Health and Mental Hygi Important: If item 27 is marked other any Injury or other traumatic event, II

Pages 1 and 2 should be

Maryland

Baltimore,

the Medical Examiner must be notified at

Director

Funeral

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Completed

Be

or Attending Physician: The law requires that the death certificate be executed

sician and burial-trans attending physician for use as the buria signed by the a

Physician/Medical

Completed by

Be

Certification: To

Medical

Division of Vital Records, P.O. Box 68760,

in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 Other			Month Day Year
Part II. Other significant conditions FAILURE T		sulting in the underlying	g cause given in Part I.		use contribute to the cause of death?
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
25. Was case referred to medical			26. Place of D	eath (Check only one)	
examiner? 1 ☐ Yes 2 ☑ 🗸 🗸 🗸 🗸	Hospital: 1 ☐ Inpatient 2 ☐] ER/Outpatient 3 ☐ I	DOA Other: 4 Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)
27. Manner of Death 1 ☑ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) on	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how injur	y occurred
3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, street, factority)	ory, office	28f. Location (Street an City or Town, State	d Number or Rural Route Number,)
	Physician: To the best of my known in aminer: On the basis of examine) and manner as stated. d place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

D0061789 NOVEMBER 15, 2011

State Registrar

LOPPAINE OFFIL-AWUMHIND. 5430 CAMPBELL BLVD, STEXIY, BALTIMORE MO 21236 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

DHMH 17 Rev 1/2001

nours after death.

neral Director: A
filled in by the fu

24 hours a the Hospital

completely within 2

11-08500 James Edward Winn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ames Edward	Win	1- For State	Department of Certificate of	of Health and Mental H of Death		a. No. 20	11 3694
Physic	ian/	1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
Medical Exam		Damed Hawara Willin			Month November	Day Year 12, 2011	0919 hrs
		Facility Name (if not institution, give street and number) 6201 Loch Raven Boulevard Apt 511		4b. City, Town, or Location of Death Baltimore	1	4c. County of E	Death
Funeral		5. Social Security Number 6. Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year If Under 24Hrs	s. 8. Date of Birth	(MM/DD/YYYY) S). Birthplace (State or
Director		223-76-3317 1XM 2DF	60 Y	Months Days Hours Min	06/17	/1951 F	oreign Country) VA
A	1	Usual Residence of Decedent					
ow any			10c. City, Town or Loca				10d. Inside City Limits 1 X Yes 2 No
Maryland 28a-f show 1 at once,	탸	MD N/A 10e. Street and Number		Baltimore Tiof. Zip Code	100	g. Citizen of What	
ith the Maryland 23a or 28a-f sho notified at once,	Director	2421 Westwood Ave.		21216		U.S.A.	
ms 23.		11. Marital Status 12. Was Decedent I		as Decedent of Hispanic Origin? (S		14. Race - A	merican Indian, Black,
r death or ite	Funeral		x No	Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, e	
rs afte ural",	δ	3 Widowed 4 Divorced of Divorced of Dates: 15. Decedent's Education (Specify only highest grade compared to the Divorced of Dates).	nleted) 16a Decede	Yes 2 X No specify:	work done	Specify: 16b. Kind of Busine	Black
72 hou	eted	Elementary/Secondary (0-12) College (1-4 or 5	during r	most of working life. DO NOT use reti		Johns H	
vithin ene.	Completed	12th Grade	Flo	or Tech		Univer	sity
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland beparament of Health and Mornell Hygiens "matural", or items 23a or 23a-f she important! If litem? 71 is marked other than "matural", or items 23a or 23a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Be Co	17. Father's Name (First, Middle, Last) John Rufus Winn			e (First, Middle, Ma e Welfu	aiden Surname) S Evans	
212 212 ould be Ment mark	To B	19a. Informant's Name/Relationship (Type, Print)	19b. Mailir	ng Address (Street and Number or I	Rural Route Numb	er, City or Town, S	State, Zip Code)
MD d 2 sho lth and n 27 is	ľ	Barbara Winn(wife)		Westwood Ave			
ore, s 1 an of Hea If iter		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State		sition (Name of cemetery, ther place)	Date	20c. Location - Cit	ty or Town, State
Baltimore, permit. Pages 1 as Department of He Important: If ite		4 Donation 5 Other Specify:				Baltimo	
Ball permit Depar Impo		21. Signature of Funeral Service Licensee	$n = \begin{bmatrix} \frac{3}{2} \\ 21 \end{bmatrix}$	Name of Market Name of British Name of State of	Jr. Fu Ave. B	neral H altimor	ome PA e, MD21217
Physician		23a. Part I. Enter the disease, or complications that caused to failure. List only one cause on each line.					Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Hypertensive Ath		liovascular Disease			Death
		or condition resulting in death) Due to (or as a consect	quence of):				
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	quence of):		•		
=	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consect	quence of):				
6 be executed ysician and burial - transit		d.					
50, te be exe ysician	Medical	UNPENDED AMENDED IF FEMALE: 23c. If yes, outcome	o of programmy			22d Date of doll	
OX 6876(eath certificate attending physe	ᇙ	23b. Was decedent pregnant in the past 12 months?	2 🔲 Fe	etal death 3 Ectopic pregna	incy	23d. Date of deli Month	Day Year
Box 6876 e death certificate the attending phy ed for use as the l	Physici	1 Yes 2 No 9 Unknown 9 Unknown	ime of death 5 0	ther (Specify)			
O. Bo at the de I by the tached fi		Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute	e to the cause of death?
s, P.O lires that t signed by d be detac	d by				1 Yes	2 No 3	Probably 4 🗹 Unknown
of Vital Records, ng Physician: The law require After this certificate has been simeral director, page 2 should b	Completed				24a. Was an autopsy	prior	e autopsy findings available to completion of cause of
tal Rec cian: The la certificate h	등				perform 1 ✓ Yes 2		n? Yes 2 No
ician: ician: s certifi rector,	Ba	25. Was case referred to medical examiner? Hospital: 1 Inpatien	nt 2 ER/Outpatien	26.Place of Death (Check of the 3 DOA Other Warsin			
of V g Phys fter thii	입	1 Yes 2 No Impatient 27. Manner of Death 28a. Date of Injun	y 28b. Time of			esidence 6 🗸 0 w injury occurred	itner: Scene
ion (tending eath.	ţi	1 V Natural 5 Pending (Month, Day, Yes	ar)	1 Yes 2 No			
Division tal or Attendii ts after death. "I Director: A	Certification:	3 Suicide 6 Could not be 28e. Place of Inju	ıry - At home, farm, stre	et, factory, office building, etc.	28f. Location (Str or Town, Sta		r Rural Route Number, City
Ospital ospital bours a meral 1		4 Homicide determined (Specify) 29a. Certifier , Cartifier Broad Table 1				<u> </u>	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 buours after Attending Physician: The law requires that the death certificate within 20 the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b	Medical	one) 2 Medical Examiner: On the basis of exam					
S H K H	Me	29b. Signature and title of certifier		29c. License number	12	29d. Date signed ((Month, Day, Year)
		anet 2		O.C.M.E.		November 13,	, 2011
		30. Name and address of person who completed cause of de Ana Rubio MD. Assistant Medical Exami		timore Street, Baltimore, MD	21223		
St	ate	31. Date filed (Month, Day, Year) 32. Registrar:	01				
Regis	rar	NOV 1 8 2011 Seven	N B. 190	alel			

30.4 0 with the Maryland Baltimore, Maryland 21215-0036 roppor Composi

for State Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 6:30 November 2011 Ам James John Zebron, Jr. Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7623 Hillendale Road Baltimore Apt. Baltimore Social Security Number If Under 1 Year If Under 24 Hrs . Age (In yrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 5ex 1X☐ M 2 ☐ F Country) Maryland Months Nov 18, Year 942 Hours **Director** 219-38-6449 68 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 28a-f MD 1 Yes 2X No Baltimore Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 7623 Hillendale Road 21234 **USA** Apt. G 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 X Yes 2 If Yes, Give Black, White, etc. "natural", or þ 1 Never Married 2 Married 2 No 1 ☐ Yes 2 XNo Specify. Completed 3 Widowed 4 Divorced Specify: white Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Rock City Church Audio Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James John Zebron, Sr. other traumatic Catherine Style 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Victor J. Zebron 7623 Hillendale Road Apt. G; Baltimore, MD 21234 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 premation 3 Removal from State 4 Donation Dther (Specify) Holy Cross Cemetery 11/18/2011 Brooklyn Park, MD Signature of Funeral Sprice 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or compli shock, or heart failure. List only one ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final √Ph sician/ disease or condition DAIMSC Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami and resulting in death) Last Due to (or as a consequence of): physician a sthe burial-To the Hospital or Attending Physician: The law requires that the death certificate be eximin. 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia completed filled in by the funeral director, page 2 should be detached for use as the burn Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes 2 🗆 No Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital 2 🗆 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 - Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29c. License number 29d. Date signed (Month, Day, Year) S death (Item 23a) (Type, Print) Trim 31. Date filed (enth, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar amend 7 per bc. g921 11/18/Certificate of Death 2. Date of Death 2118 Mont Physician/ Medical 4a. Facility Name (if not institution, give street and 4b. City, Town, or Location of Death Examiner REGIONAL NICOMICE TENINSULA Birthplace (State or Foreign Country) If Unde 8. Date of Birth (Month, Day, Year) **Funeral** Months Director 1 🗆 M 2 🗶 F 10-4-2011 MD 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10h County items 23a or 28a-f sho ler must be notified at Director 1 Yes 2X No Pocomoke City MD Worcester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 21851 USA 722 6th Street death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, i "natural", or item ledical Examiner n 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces? Black, White, etc. þ 1 X Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 SpecifyBlack If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Completed 3 Widowed 4 Divorced of Health and Mental Hygiene.
item 27 is marked other than "natur other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) None Ô None Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ Ouadera N. Mills Xavier L. Arnold, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Quadera N. Mills/Mother 722 6th St, Pocomoke City, MD 21851 : If item ? 20b. Place of Disposition (Name of T.T.C Date 20c. Location - City or Tov cemetery, crematory or other place)

Direct Cremation, 10-20-2011 Dover, DE 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or Donation 5 Other (Specify) Hennie Action 1917 W. Isabella St. Signature of Frineral Service Licensee Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or Injury and burial-tra that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate being hours after death.
Funeral Director: After this certificate has been signed by the attending physicis P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Unknown signed by ti Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Nuknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has death? 1 1 Yes 2 1 No performed? Yes 2 No Division of Vital сотрыетель filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 🕅 No ၉ 1 🔏 Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 27. Manner of Death 28b. Time of 28d Describe how injury occurred X Natural iniury 5 Pending Accider
Suicide Investigation Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 24 hours a Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and titl 29d. Date signed (Month, Day, Year)

Registrar DHMH 17 Rev 06-2011

State

MILHELLE 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) URBAN

20

OCT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month Alice Marie Brown 2011 November 6 4b. City, Town, or Location of Death 4c. County of Death Smithsburg Washington 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 1 M 2 X Days Min. 78 Yrs July 20. Maruland 10h County 10c. City, Town or Location Washington Smithsburg 10f. Zip Code 10g. Citizen of What Country? 21783 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 X No

1 - State Registrar 1. Decedent's Name (First, Middle, Last) Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner 26 Maple Ave. 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 220-28-8099 **Director** Usual Residence of Decedent shov 10a. State 10d. Inside City Limits the Maryland Director notified 28a-f 1 Yes 2 No Maryland 10e. Street and Number ö must be 23a Funeral death with 26 Maple Ave. items 11. Marital Status δ ō 1 Yes 2 If Yes, Give Year or Dates. 1 Never Married 2 X Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: "natural" Completed 3 Widowed 4 Divorced White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) Hygiene. College (1-4 or 5+) 11 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental Hitem 27 is marked ot other traumatic even ဂ္ Keifer Lewis Eleanor Glenn 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a 26 Maple Ave. Smithsburg, Maryland 21783 Lester Brown, Jr. (Husband) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, November <u>₩</u> ፟ Department o Important: If any injury or Cavetown, Maryland Cavetown Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 10, 2011 Signature of Funeral Service Licenses 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Ph i ian/ month disease or condition 10 Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to for as a nonsequence off attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death ed by the aidetached for Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 XYes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy performed? Yes No this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify ဂ္ဂ 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at work? 24 hours after death. Funeral Director: After 1 Natural 5 Pending injury 2 🗆 No Accident Investigation 1 Yes completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 🛇 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check the only one within To the 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year, 0 and address of person who completed cause of death (Item 23a) (Type, Print) NWOTA Date filed (Month, Day, Year) 32. Registrar's Signature State 8 racks

DHMH 17 Rev 7/2009

Registrar

11-08099 Amon R Brown, Jr. Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

non R Brown,	Jr.	State of Maryland / Departm			and	Mental	Hygiene	0.0		0.001
Physicia	m/	Registrar 1. Decedent's Name (First, Middle,Last)	ale UI	Dealli			2. Date of Dea	Reg. No.	113	. Time of Death
ledical Exami		Amon R. Brown, Jr.					Month October 2	Day Year 28, 2011		1208 hrs
		4a. Facility Name (if not institution, give street and number)	4			cation of De	eath	4c. County of [eath	
		2100 Deer Run Court		Hunting				Calvert		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bit	rthday)	If Under	Days	If Under 24 Hours	Min	irth(MM/DD/YYYY) S	oreign	· ·
Director		217-32-1140 1x M 2 F 75	Yrs.				10/09	/1936	Count	try) DC
any		10a. State 10b. County 10c. City, Town	n or Location	on					11	Dd. Inside City Limits
	_	MD Calvert Hunti	ngtow	'n					1	Yes 2 X No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number		10f. Zip Co	ode			10g. Citizen of What	Country	n
n the Maryland 3a or 28a-f sho otified at once.		2100 Deer Run Court		2	0639	9		United S	tate	es
h with	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?					(Specify Yes or No erto Rican, etc.)	o- 14. Race - A White, e		n Indian, Black,
er deal		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year		Yes 2X				Specify:	Whi	te
irs afte	ò	or Dates:	_	La Colorado Part			of work done	16b. Kind of Busin		
72 hou	etec	Elementary/Secondary (0-12) College (1-4 or 5+)				O NOT use		1		
036 rithin and and and and and and and and and an	Completed	12 M	aster	Elec	trio	cian		Automo	tiνε	e
1215-0036 Id be filed within 72 hours fental Hygiene. arked other than "natur event, the Medical Exami		17. Father's Name (First, Middle, Last)			- 1			Maiden Surname)		
21215-0036 sold be filed within 72 Mental Hygiene. marked other than ic event, the Medical	Be	Amon R. Brown, Sr. 19a. Informant's Name/Relationship (Type, Print) 15	h Mailing	Address			y E. Col	11NSON mber, City or Town, 9	State 7	in Code)
MD 21215-0036 ad 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. m 27 is marked other than "matural", or items 23a or 28a-f she aumatic event, the Medical Examiner must be notified at once	ဠ							gtown, MD		
		20a. Method of Disposition 20b. Place	of Disposi	tion (Name	of ceme		Date	20c. Location - Ci		
Baltimore, permit. Pages I an Department of Heal important: If iten njury or other tra		1 X Burial 2 Cremation 3 Removal from State Chesa	peake	_{er place)} High lar Irdens	nds	11	/04/2011	Port Repu	hlic	MD
Baltimo permit. Page Department o Important: injury or oth		4 Doration 5 Other Specify: Memor 21. Synature of Funeral Service Licensee	22. No	ame and Ad	dress of			al Home C		
EEE C		Jary J. Golf						gs, MD 20		
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do n failure. List only one cause on each line.	ot enter th	e mode of d	lying, su	ich as cardia	c or respiratory ar	rest, shock, or heart		Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease	Head						ightharpoonup	Death
		or condition resulting in death) Due to (or as a consequence of):								
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):							\dashv	
	ami	cause. Enter Underlying Cause (Disease or injury that initiated vents resulting in death) Last Due to (or as a consequence of):							\dashv	
executed an and al - transit	Ĕ	events resulting in death) Last Due to (or as a consequence or): d.								
0, be execut sician and surial - tra	dical Examiner	UNPENDED AMENDED								
		IF FEMALE: 23c. If yes, outcome of pregnancy)= . ·		23d. Date of de		
Box 6876: death certificate the attending physical for use as the b	Physician/M	past 12 months?		al death er <i>(Specify</i>		Ectopic pre	gnancy	Month	Day	Year
- 0 4	ysi	1 Yes 2 No 9 Unknown 9 Unknown	о <u>П</u> Ош	er (opcon)	′ —					
	by P	Part II. Other significant conditions contributing to death but not resulting	ng in the ur	nderlying ca	use give	en in Part I.		obacco use contribut		
of Vital Records, P.O. of Physician: The law requires that the there this certificate has been signed by meral director, page 2 should be detacal								s 2 No 3		
ord iw req as bee	E E			_			24a. Was	psy prio	r to com	sy findings available pletion of cause of
Rec The la	Completed						1 ✓ Yes	ormed? dea 2 No 1 ✓	Yes	2 No
cian: certifi	Be	25. Was case referred to medical examiner? Hospital: 4 leasting 2 FR/C			I Ot	hor 🗔	ck only one)			
F Vi Physical this	은	1 ✓ Yes 2 No	Outpatient Time of In			at Work?		Residence 6 🗹)ther: S	сепе
	<u>ë</u>	1 Natural 5 Pending FOUND: Day, Year) FOUND:	UND:			2 V No	Subject sho			
Division of Vitz ital or Attending Physicis us after death.	ficat	2 Accident Investigation Oct 28, 2011 114	5 hrs arm, street				28f. Location (Street and Number of	r Rural	Route Number, City
Division pital or Att tours after dours after dours after dours after diffiled in by	Certification	3 ✓ Suicide 6 Could not be determined (Specify) Backyard					or Town, 3 2100 Deer R	State) un Court , Hunting	town, f	MD
Hosp 74 ho Func		29a. Certifier 1 Certifying Physician: To the best of my knowledge, de	ath occurr	ed at the tin	ne, date	and place,	and due to the cau	se(s) and manner as	stated.	
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: complesely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigati				ed at the time, date			
	Σ	29b. Signature and title of certifier		1	icense n			29d. Date signed		, Day, Year)
		Mell Brassell MD).C.M.	E.		October 29, 2	:011	
Jew 11		 Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 	900 W	Baltimo	re Stre	eet. Baltir	nore, MD 212	23		
17 mg	ate	31. Date filed (Month, Day Year) 32. Registrar's Signature	- 7		.5 5(16	Joi, Daill				
Regist		NOV - 2 2011 /2	ha	N. I						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hydiene

		1	For State Registrar		State of Ma	aryiand	•	tificate of E		ia ivie		eg. No.	2011	36950
	Physicia		1. Decedent's Name				_	1			Date of Deat Month October		2011	3. Time of Death 10:34 A M
	Medic	al .	Willian 4a. Facility Name (if		Oscar		B	4b. City, Town, or	r Location of D		Jecober	_	ounty of Death	10:54 A
	Examin	er		Pennsylva				Hagerst				Wa	shingto	
	Funeral Director		5. Social Security Nu 193-22-06		ex M 2 □ F 83	(In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 6	Date of Birth Month Day 6/192	Year)	g. Birth Cour Ohio	place (State or Foreign etry)
	nd how at	١.	Usual Residence of 10a. State	Decedent 10b. County		10c. City	, Town or Loc	ation					1	10d. Inside City Limits
	/laryla // Ba-fs tified	rect	MD	Washing	ton	Hag	gersto	wn.						1 🗌 Yes 2 🔭 o
	n the N a or 2 be no	Funeral Director	10e. Street and Nun					10f. Zip Code	= 1.0		1	J	en of What Cou	ntry?
	ns 23 must	neur		ennsylvan	ia Ave.	ver in U.S	. 13. V		742 Iispanic Origin	n? (Specif	y Yes or No-		J.S.A. 4. Race - Americ	can Indian,
326	should be filed within 72 hours after death with the Maryland n and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	d by Fu	11. Marital Status1 ☐ Never Marri3 ☐ Widowed	ied 2 Married 4 Divorced	Armed Forces? 1 Yes 2 If Yes, Give Year or Dates.		- 1	Vas Decedent of H Yes, specify Cuba		Puèrto Ric	an, etc.)		Black, White, pec <i>ify:</i> Whi	etc.
Maryland 21215-0036	2 hours "natur edical I	Completed	(Spe	15. Decedent's E			(Give F	lent's Usual Occur	during most o	of working		16b. Kind	d of Business Ir	ndustry
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א פ	illed w al Hygi I other vent, t	Be	17. Father's Name (i	First, Middle, Last)			11001		18. Mother	's Name (F	irst, Middle, f			
ylar	Menta	မ	William			_			Sadie		ley	O'1	Ctata Zin	Codel
Mar	1 and 2 should be of Health and Menta fitem 27 is marked rother traumatic e		19a. Informant's Na Kathleen					ng Address (Street B Pennsy1						
	1 and 2 s if Health item 27 other tr		20a. Method of Disp	position			lace of Dispo	sition (Name of natory or other pla		Da			ation - City or T	
altimore,	Page 1 ment of ant: If it ury or c		1 Burial 2 4 □ Donation	☐ Cremation 3 ☐ 5 ☐ Other (Speci	Removal from State	- 1	-	n Cemete	1	./5/2	011	Hage	rstown,	Maryland
Balti	permit. Page 1 Department of Important: If it any injury or once.		> CW	neral Sonice Licen	Mino		11	Name and Address	svlvan	ia Av	re. Hag	erst	neral	Chapel 21742
			23a. Part 1. Enter t shock, or hea Immediate Cause	rt failure. List only	nplications that caused one cause on each line	Э.	n. Do not ente	er the mode of dyi	ng, such as ca	ardiac or r	espiratory arre	est,		Approximate Interval Between Opset and Death 1-2 years
	Pnysician/ ∤ Medical		disease or condition resulting in death)		a. Due to (or as			small c	ell)					1 2 years
	Examiner	<u>.</u>	Sequentially list co	onditions,	b. —									
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	cate be executed physician and the burial-transit	Exa	that initiated event resulting in death)		Due to (or as	a consequ	ience of):							
200	te be (hysicia he bur	edical			d									
687	ath certifica attending p for use as t	/Me	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, outcome	of pregna	ncy	7				2	3d. Date of del	ivery
Box 687	the death c by the atten tached for u	Physician/M	in the past 12 1 Yes 2 9 Unknown	months?	1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown			☐ Ectopic pregnar ☐ Other (specify) _	ncy				Month	Day Year
, P.O.	or Attending Physician; The law requires that the death certificate be executed after death. Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit in by the funeral director, page 2.	b	Part II. Other signi	ificant conditions	contributing to death l	out not res	sulting in the u	underlying cause g	given in Part I.					the cause of death?
ords	require been s should	Completed									24a. Was	an	24b. Were au	topsy findings available completion of cause of
Seco	The law cate has page 2	omp									autor perfo 1 \(\sum \text{Yes}	osy irmed? 2 M No		2 No
a F	ysician: The is certificate director, pag	BeC	25. Was case refer examiner?		Hoopitali				Place of Death		only one)			
Ţ	Physic this ce ral dire	은	1 Yes 2		Hospital: 1 Inpat		ER/Outpatie	nt 3 ∐ DOA			ne 5 🛣 Resid Bd. Describe h		Other (Spec	ify)
0 U	ath. : After e fune	cate	1 X Natural 2 Accident	5 Pending Investigation	(Month, Da	y, Year)	injury	wo	rk? □ Yes 2 □	No				
Division of Vital Records,	I or Attending Ph after death. Director: After th I in by the funeral	Certificate:	3 Suicide 4 Homicide	6 Could not determined		ury - At ho c. (Specif)	ome, farm, st	reet, factory, office		2	8f. Location (\$ City or Tow	Street and vn, State)	Number or Ru	ral Route Number,
	To the Hospital or within 24 hours af To the Funeral Discompleted filled in	Medical	/O1	O Madical Ever	ysician: To the best o miner: On the basis of irse Practioner: To the	oveminatio	n and/or inve	stigation in my onli	nion, death oc	curred at t	he time, date a	and place,	and due to the	cause(s) and mariner stated
	To the within ! To the comple	Ž	only one) 29b. Signature and	title of certifier		// Nest of m	ıy Kriowieage,		se number	ли расс	, and dus to th		e signed (Monti	
	X			Rich	and t	ful			49878	٧Ā		11	/2/11	
	vet			ress of person who	completed cause of Ft. Detr			Print) C-1344 I	Orter	St	Frede	rick	. MD 2	1702
	Sta		31. Date filed (Mor	nth, Day, Year)	32. Fegist		A	C-1344 1	OL COL	50.,	11040		,	
	Regist	rar		MOV O &	2011 1840	The Paris	10 10	A STATE OF THE PARTY OF THE PAR						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend#5perFH11/9/11DCCCHD Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 03 8:20 EANOR 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1Attsville Prince Thoma 5. Scial Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace Country) 6. Sex 8 Date of Rirth Funeral 7. Age (In vrs. last hirthday) (Month, Day, Year) 1 M 2 X F 86 Director ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County Id be filed within 72 hours after death with the Maryland Mental Hygiene. 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Marzaland 10e. Street and Number 10g. Citizen of What Country? Funeral ["natural", or items 23a 2901 20774 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: 3 X Widowed 4 Divorced Black Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical! 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemakerz Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aiken JAnice 20774 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 A Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) MI) 4 ☐ Donation 5 ☐ Other (Specify) 11-10-2011 incoln 21. Signature of Juneral Service Livensee 22. Name and Address of Facility 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death a Anitruscetononic CAANOVA SEURA Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav 1 Yes 2 No been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Reproatory Failure / Whitelator Dependence 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellits Anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an Jas autopsy performed? Yes 2 1 No Atrial Fibrillation HypoThyroid peritanson 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 🗷 No Other: ျှ 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4

✓ Nursing Home 5

Residence 6

Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 S Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier 🗖 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier D01852 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) RODUS GORGE HOUTS : 1/2 MD 20781 DC Ą MD 4203 DEVURE

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MOA

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Novembe Physician/ 145AM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Pineview uture care Inton 8. Date of Birth 9. Birthplace State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birtipian (Couptry) W 45h/ngton **Funeral** (Month, Day, 1 🗆 M 2 💥 F Months Director 217-32-0363 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No WALdor Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 2060 11832 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 🔼 No Black, White, etc. 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes. Give 3 Widowed 4 Divorced Black Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hospita 12 Be 18. Mother's Name (First, Middle, Maiden Surna 17. Father's Name (First, Middle, Last) ဂ္ John or Rural Route Number, City or Town, State, Zip, Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number Walder 20601 Sterling 20a. Method of Disposition City or Town, State 20b. Place of Disposition (Name of Date 1 🕅 Burial 2 🗆 Cremation 3 🗀 Removal from State cemetery, crematory or other place MI Donation 5 Other (Specify) M. Name and Address of Facility Signature of Funeral Service Licenses 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cardiovescular Physician/ Atherosc Wiseas e 200 disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) rany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day 5 Other (specify) 1 Yes 2 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Nown Rena 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed' 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 🖪 No မှ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work? 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only on 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Smi 8 203 31. Date filed (Month) 32. Registrar's Signatur State NOV U & ZUIT Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ NOVEMBER 6 2011 5:23 A RAYMOND LEVI BLAKE, JR. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** CHARLES RESIDENCE. 206 BERTHA CIRCLE INDIAN HEAD If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Director 69 218-38-6632 1 **X**M 2 □ F Yrs DECEMBER 24,1941 MARYLAND Usual Residence of Decedent 10d. Inside City Limits or 28a-f shov 10c. City. Town or Location 10a. State 10b. Count Examiner must be notified at Director 1 X Yes 2 No INDIAN HEAD MARYLAND CHARLES 10g. Citizen of What Country? 10e. Street and Numbe 10f. Zip Code Funeral items 23a UNITED STATES 20640 206 BERTHA CIRCLE 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 11. Marital Status 14. Race - American Indian Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc ò 1 Never Married 2 Married by 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: BLACK "natural", 3 Widowed 4 Divorced Completed Medical 16b. Kind of Business/Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the FEDERAL GOVERNMENT EXPLOSIVE WORKER 1 YEAR traumatic event, Be 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) DOROTHY ANNETTE FORD LEVI RAYMOND BLAKE permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is mark, any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 20640 206 BERTHA CIRCLE, INDIAN HEAD, MARYLAND THERESA G. BLAKE / WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a, Method of Disposition Date 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place, CHARLES CEMETERY NOVEMBER 12,2011 GLYMONT, MARYLAND Donation 5 Other (Specify) ture of Funeral Service Licensee 22. Name and Address of Facility
THORNTON FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 THORNTON JOHNSON MO0583 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ PANCREAS CANCER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Month Pregnant at time of death 2 No g Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ pe 1 Yes 2 No 3 Probably 4 V Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an pade performed certificate Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner? Hospital Other: 4 Nursing Home 5 X Residence 6 Other (Specify, 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ျ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 5 Pending 1 Yes 2 No after death. 2 Accident Investigation completely filled in by the 6 Could not be

Registrar

24 hours a

within 2 To the

Medical

Suicide

4 Homicide

3 🗌

KRISHAN MATHUR, M.D.

29b. Signature and title of certifie

29a. Certifie (Check

31. Date filed (Mon

determined

NOV 0 & 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the Maryland

be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

DHMH 17 Rev 06-2011

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

P.O. BOX 1703, LA PLATA, MARYLAND

D 28352

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

32. Registrar's Signature

28f. Location (Street and Number or Rural Route Number, City or Town, State)

11-7-11

20646

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36954 Reg. No. 201 1 - State
Registrar Amend#5perfuneralhome11/8/2011ccdoh Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Ober Day 28 Physician/ Brady Peggy 12:55 P M 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince Georges 12809 Brandywine Rd. Brandywine If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, S5795e56144561Pe **Funeral** Months Hours 228 44 2351 **Director** 1 M 2 XXF 69 Yrs June 1, 1942 Virginia Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2XX No Maryland Prince Georges Brandywine 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 12809 Brandywine Rd. 20613 U.S . A Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Examiner Black, White, etc. 9 1 Never Married 2 X Married should be filed within 72 hours after a nand Mental Hygiene.

Is marked other than "natural", or þ 1 ☐ Yes XX No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes XX No Specify: Completed 3 Widowed 4 Divorced f Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Bus Aid Transportation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, 2 Paul Collins Violet Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Fred Robinson (Husband) 12809 Brandywine Rd. Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite 1 Burial XX Cremation 3 Removal from State 4 Donation 5 Other (Specify) injury or Nov. 2, 2011 Clinton, MD Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc. ure of Funeral Service Licens mo1555 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final LUNG Lancer Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or injury that initiated events the burial-trar Due to (or as a consequence of): resulting in death) Last attending physician I for use as the buria Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? signed by the atte Month Day Year Pregnant at time of death 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 🗌 No 1 🗌 Yes Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 2 🖾 No Other: ္ဝ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury work? 1 ☐ Yes 2 ☐ No Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10128/11 nskaj apalne M.D 00057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore MD 21209 ID DC S Rajapakse, M.D 2835 Smith AV

State Registrar 31. Date filed (Month Pay, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36955 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Oct obe 625 Linda Buckler Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Upper Marlboro Prince George's 9102 Dandelion Lane 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months (Month, Day, Year) Days Hours Virginia Yrs Director 235 52 2220 1931 Oct 31 Usual Residence of Decedent show 10a. State 10b. County 10d. Inside City Limits with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location Director 1 Yes 2 X No Maryland Upper Marlboro Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20772 9102 Dandelion Lane United States Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married 1 Yes 2 No
If Yes, Give XX
Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed 3 Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. d other than " Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 7th Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Blanche Dve Benton McCormick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sally Comer (niece) 4309 Birdie Court, Mint Hill, N.C. 28227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🔲 Burial 2 🗓 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 31, 2011 Clinton, MD Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road, Clinton, MD 20735 MO1549 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician Atherose disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, leading to immedicause. Enter Underlying Que to for as a consequence of: burial-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the burla Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Pregnant at time of death 5 Other (specify) ☐ Pregnam. ☐ Unknown signed by the a detached g Unknown Hospital or Attending Physician: The law requires that the t24 hours after death.
Funeral Director: After this certificate has been signed by th Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 3 Probably 4 Unknown 2 No Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an 1 Yes 2 No 2 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examine? 1 Yes 2 No Į. Hospital: Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 \sum Yes 2 \sum No injury 1 Natural 5 Pending Accident Investigation completed filled in by the ∴ Acciden
 ∴ Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined

within 2

State Registrar

Medical

29a. Certifier

(Check

only one

30. Name and address of person who completed cause of death (Item 23a) (Type, Pring

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1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or inventionities in the state of the cause of examination and/or inventionities in the state of the cause of

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month. Day, Year)

2011

BRYANT COTHERINE altimore, Maryland 21215-0036

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	Phy I Ex
Division of Vital Records, P.O. Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be executed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Control Physician/ 2011 Catherine Mae Bryant Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince Georges Doctor's Hospital Lanham 8. Date of Birth (Month, Day, Year) Nov. 20, 1942 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign **Funeral** Washington, 1 □ M 2**X**(X) F Nov. **Director** 68 212 62 2093 Usual Residence of Decedent 28a-f show il Hygiene. I other than "natural", or items 23a or 28a-f shov vent, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 X No Maryland Prince Georges Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A 9501 Beech Park St. 20743 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc ģ 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify: If Yes Give Specify: White XX Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker injury or other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) n and Mental F ဂ္ Ida V. Reid Harry A. Burch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 4200 Shelton Dr. Pomfret, MD 20675 Randolph Ballard (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place 1 Burial 2 XX remation 3 Removal from State 4 Donation 5 Other (Specify) Nov. 4, 2011 Clinton, MD Lee Crematory 22. Name and Address of Facility Lee Funeral Home, Inc. 21. Sign there of Funeral Service Ligen 6633 Old Alexandria Ferry Rd. Clinton, MD 20735 moc 23a. 27t 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, snock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final sician/ sepsis disease or condition **dedical** resulting in death) Due to (or as a consequence of) aminer -ailure espira tor Sequentially list conditions, If any Lading Laimm diate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examir attending physician and for use as the burial-transit Cardunyo Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death nse 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No ate has been signed by the atte page 2 should be detached for 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy performed within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s prior to completion of cause of death? 1 Yes 2 No Yes 2 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ဂ္ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 2 Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D6590 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) huck Rd. Larkam 8118 600d

State

Registrar

32. Régistrar's Signature

0 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death November Day 2011 Physician/ Queen Ester Batts 7:39 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Clinton Southern Maryland Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number . Age (In yrs. last birthday) 8. Date of Birth **Funeral** Davs Hours 577 36 3621 89 Director 1 🗆 M 2**X**] F 04/12/1922 N.C. Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location with the Maryland 10a. State notified at Director 28a-f 1 X Yes 2 No Prince George's Temple Hills 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral USA 4006 Beachcraft Court 20748 12 Was Decedent Ever in LLS 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Examiner rmed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc. 0 þ 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examir Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Black Completed 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Fiber Manufactory Operator 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Crummer Farmer Mary Jane Battle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4006 Beachcraft Ct. Temple Hills, MD 20748 Jacqueline L. Batts/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 X Burial 2 Cremation 3 Removal from State Gardens of Gethse. 11/9/2011 Rocky Mount, NC 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityHunter-Odom Funeral Service 21. Signature of Funeral Service Licer PO Box 1239, Rocky Mount, NC 27802 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final P v ici n/ DV 12 disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last County for as a consequence off the burial-transit The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760 use as IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 5 Other (specify) Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ Cardiovascular 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed Yes 2 death?
1 Yes 2 No Dabo tes certificate the Hospital or Attending Physician: 25. Was case referred to medical filled in by the funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) Medical Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated ☐ Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 06-2011

State

30. Name and address of person who

NOV

·Lterbert

Date filed (Month, Day, Year

11701

ringston Rd #205 A. Washington

completed cause of death (item 23a) (Type, Print)

egistrar's Signature

shington

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year JOHN LARRY CUSIC EMBER 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** MEDICAL PLATA LA CIVISTA ENTER CHAR C 9. Birthplace (State or Foreign MD • 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth Funeral Days 1 XM 2 1 F 9/onth, 4ay, Year 43 452-68-6255 68 Yrs. Director Usual Residence of Decedent 10a, State 10b County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Completed by Funeral Director CHARLES MD. WHITE PLAINS 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4001 HANSON ROAD 20695 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married 21215-0036 1 Yes If Yes, Give 2 No Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify Specify: WHITE If item 27 is marked other than "natural", or other traumatic event, the Medical Exa 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) G.S.A. Elementary/Seconday (0-12) College (1-4 or 5+) nd Mental Hygiene. marked other tha STEAMFITTER/PLUMBER U.S.GOVT 9th Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ GEORGE S. CUSIC AGNES BEATRICE WOOD and l 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra SHARON CUSIC-SPOUSE 4001 HANSON RD. WHITE PLAINS, MD. 20695 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METROPOLITAN CREMATORY 11-18-11 M00479 . Signature of uneral Service Licensee 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 236. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one caus Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). Cause (Disease or iinjury the burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical pe 68760 or Attending Physician; The law requires that the death certificate use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Box in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav signed by the P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed this certificate 1 ☐ Yes 2 ☐ No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1 🖵 Yes 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 1 Acertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопріеть (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 29b. Signature 29d. Date signed (Month, Day, Year) 201 ompleted cause of death (Item 23a) (Type, Print) 8 OFFICE

DHMH 17 Rev 7/2009

State Registrar

2715/2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend items 10a-c, e, f per inf g921 11-21-11 vt
State of Maryland / Department of Health and Mental Hygiene State Registrar 36959 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 31. 2011 9:15P M Frances Boughter Conner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6075 Manor Lane La Plata Charles 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Days Months Hours November 30,1919 Country) 119-07-4514 91 PADirector Usual Residence of Decedent 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Director Polk Florida Davenport 1 🗆 Yes 2 🔀 No Charles La Plata 10e. Street and Number 620 Powerline Road 10f. Zip Code 10g, Citizen of What Country? 33837 Funeral 20646 USA death \ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify If Yes, Give Year or Dates Completed 3 XWidowed 4 ☐ Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done life. DO NOT use retired) during most of working and 2 should be filed within 72 Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Registered Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Nathaniel Boughter M. Irene Malone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any Injury or other trau Susan Morgan/Daughter P.O. Box 1998 Davenport, FL 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols 11/3/2011 Charlotte Hall,MD 21. Signature of Euneral Service License 22 AREHARTEECHOUS FUNERAL HOME, P.A. 211 St. Mary's Ave. La Plata,MD 23a. Part 1. Enter the disease, or compile ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner CON Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the at d be detached for g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.

To the Funeral Director: After this certificate has been sign 1 Yes 2 No 3 Probably 4Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No Yes Division of Vital 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 2 140 Other: 1 \square Yes ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred iniury Natural 5 Pending work? Accident Suicide Investigation M the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PO 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36960 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 07:12 PM DANIEL W COFFEL 2011 Medical 4a. Facility Name (if not institution, give street and number) 22 50 274 (Seen: 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMONE UNIVERSITY OF MANY LAND BALTIMORE CITY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Hours 7-12-1957 385-62-1882 MICH. 54 **Director** Usual Residence of Decedent 28a-f show ms 23a or 28a-f sho must be notified at 10c. City. Town or Location 10d. Inside City Limits Director WALDORF MD. CHARLES 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23 GREYSTONE CIRCLE 20602 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2X Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 SpecWHITE 1 ☐ Yes 2X No Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I.B.E.W. Elementary/Secondary (0-12) College (1-4 or 5+) MASTER ELECTRICIAN LOCAL 26 1 Ź Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JERRY WAYNE COFFEL SUE WORDEN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
23 GREYSTONE CIRCLE WALDORF, MD. 20602 LORI COFFEL-SPOUSE I and 2 s Health a 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) ATLANTIC CREMATORY 11-13-11 GLEN BURNIE, MD. 21. Signature of Funeral Service Licensee Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 ₩00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final (LIVER CIRRHOSIS Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** ALCOHOLISM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Li Fetal doc.

Pregnant at time of death
Unknown 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ACUTE TUBULAN NECLOSIS Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed ASPIRATION ENEUMONIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 1316172240 MB MV 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENE ST BALTIMORE, MD MICHAEL Calleron SOUTH

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	, 		1 - For State Registrar	State of I	Maryland /		rtment o					Reg. No.	21111	36961
	Physici	an	Decedent's Name (First, Middle	•							. Date of De Month	Day		3. Time of Death
	/Medic Examir		4a. Facility Name (If not institution	e Carter-G			4b. City, To	wn, or	Location of		Novemb		O, 2011 County of Death	1:45 P.™
	Exami	iei	Coffman Nursi						town			W	ashingto	
	Funeral Director		5. Social Security Number 236-56-2932 Usual Residence of Decedent	6. Sex 7. 1 □ M 2 □ F	Age (In yrs. last b	birthday) Yrs.	If Under 1 Months C	Year Days	If Under 2 Hours	Min.	Date of Bird (Month, Da March	th 19. Year) 2,19	9. Birth Cour 38 West	place (State or Foreign ntry) Vinginia
	Maryland -f show	tor	10a. State 10b. County	ington	10c. City, To		cation S town						1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	with the	Funeral Director	10e. Street and Number 13905 Penns	ylvania Avo	e.		10f. Zip Co	217	42	-		-	zen of Whal Cou	ntry?
336	within 72 hours after death with the Maryland ene. than "naturaf", or items 23e or 28e-f show he Madical Examiner must be netitied at	by	11. Marital Status 1 □ Never Married 2 ☑ Marri 3 □ Widowed 4 □ Divorced	12. Was Decede Armed Force ed 1 \(\subseteq Yes, Give \) Year or Date	s? ₹No		Vas Deceder Yes, specify		spanic Origin, Mexican,	in? (Speci , Puerto Ri	ify Yes or No can, etc.)) -	14. Race - Americ Black, White, Specify: Wh	
Maryland 21215-0036	within 72 hou ene. than "nature the Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	's Education t grade completed) College (1-4c		(Give life. L	lent's Usual C kind of work DO NOT use Police	done di retired)	uring most		7		nd of Business/In	
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ylar		To B	James C. Ca		-						ice M.			
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Baltimore,	ss 1 an of Heal item 2 r other		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S)		20b. Place	of Dispo	sition (Name natory or other g Crem	of or place) N	lov. 1	te	20c. Lo	ocation - City or To	own, State
Baltii	permit. Page Department Important: fl any injury o		21. Signature of Funeral Service I		M01414	J 22	Name and	Addres	s of Facility Fune	,	lome S	2525 mi th	Bradbur sburg,Mo	y Ave. 1.21783
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*	ed isit	iner	Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	ав а волеециало	ia of):								
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.O. Box	he death certificat the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		2 Fetal dea at time of death		Ectopic preg Other (spec					:	23d. Date of deliv Month	rery Day Year
S, D	The law requires that the de Ite has been signed by the a vage 2 should be detached t	by	Part II. Other significant condition	ns contributing to deat	n but not resulting	g in the ur	nderlying cau	se give	n in Part I.			Yes 2		the cause of death?
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Vital	Physician: The this certificate ral director, pag	o Be	25. Was case referred to medical examiner?	Hospital:				Othe	W		(Check only			
of		⊢ :	1 ☐ Yes 2 🗶 No 27. Manner of Death	28a. Date of I		. Time of		. Injury Work	4 140	7	e 5∐Resi 3d. Describe		6 □Other (Speci ry occurred	(Y)
Division	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	1 Natural 5 ☐ Pendin 2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	pation and be 28e. Place of	Injury - At home, etc. (Specify)	farm, str	М	1 🗆 Y	/es 2□l		3f. Location (City or To		nd Number or Rui	ral Route Number,
	pital or ours afte eral Dir filled in	Cerl		g Physician: To the be		las dosth	annurad at	the tim	o data an	d place, as				etalad
	A Fun	edicai	(Check only 2 Medical one)	Examiner: On the basis and manner	of examination	and/or in	estigation, ir	my op	pinion, deal	th occurred	at the time,	date and	d place, and due	to the cause(s)
)	To the To the comp	M	29b. Signature and title of certifier William	mg mg			29c. l		number 16561			29d. Da	te signed (Month	Day, Year)
	4		30. Name and address of person	who completed cause of	death (Item 23a		Print) (TWIT //			66715	الإيما	M1)	217	40
	Sta Registr		31. Date filed (Month, Day, Year) NOV 1 8 2011	32. Reg	strar's Signature	. 6								
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36962 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ JAMES, P, CUSTIS 1100 AM 10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNIVERSITY OF MARYLAND MEDICAL SYSTEMS 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Hours Min. Country) **Director** Usual Residence of Decedent items 23a or 28a-f show 10a. State 10d. Inside City Limits 10c, City, Town or Location Examiner must be notified at Director St. Michaels 1 🗷 Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? Funeral U5A remont 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 1 Yes 2 No 1956 Black, White, etc. o, ģ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. "natural", 3 ₩idowed 4 ☐ Divorced Completed Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Sanitation Company Be injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21673 Debra rean gate Nay permit. Page 1 and 2 Department of Healt Important: If item 2 20a. Method of Disposition bate 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 8/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility
Henry Funera
5.10 HUYLOCK, M 21. Signature of Funeral Service Licensee HOME, P.A. enry Funeral Home, Filo washington St. C 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ ACUTE MYELOUTIC LEUKEMIA disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** FUNGEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated as or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit NEUTROPENIA that initiated events resulting in death) Last Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 X Inpatient 2 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier Agn is, mo 1104115963 10,29,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

SOWMYA PAVIMO

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

22 S. OFKENE ST., BALTIMORE, MD, 21201

Registrar's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Leslie Ellen Curry 10 29 2011 20:40 Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anchorage Nursing Home Wicomico Salisbury Birthplace (State or Foreign Country) Social Security Number If Under 1 Year If Under 24 Hrs. 8, Date of Birth **Funeral** Age (In yrs. last birthday) 1 □ M 2 🛛 F Hours 481-86-5626 50 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "--- any injury or other than "---10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 ☐ Yes 2X No MD Worcester Ocean Pines 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20 Carriage Lane 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 X Never Married 2 ☐ Married 1 ☐ Yes If Yes, Give 2 XNo 1 ☐ Yes 2 🗵 No Specify: Specify: 3 Divorced 4 Divorced white Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/AN/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Larry D. Curry Janet F. Tole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet F. Curry / mother Carriage Lane, Ocean Pines, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 KCremation 3 Removal from State First Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) State Crem. 10/31/11 Juneral Service Li 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1. Inter the disease, or complications that caused the death, Do not enter the mode of dving, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final CANCER Physiciani UNG disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 X No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☒ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Hospital or Attending Physician; The law in 24 hours after death.
Funeral Director; After this certificate has E autopsy performed? death? 1 Yes 2 No 1 Yes 2 X No completed filled in by the funeral director, Be 25. Was case referred to medica 26. Place of Death (Check only one) Hospital: Other: 4 🔀 Nursing Home 5 🗌 Residence 6 🗀 Other (Specify) 2 No မ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d, Describe how injury occurred Certificate: 1 🛣 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State) To the Hospital within 24 hours a To the Funeral D Medical

9400 State

31. Date filed (Month, Day, Year) NOV 0

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Des

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

29a. Certifier

(Check

only one)

#504B, Salisbury 106 Milford ST egistrar's Signature

29d. Date signed (Month, Day, Year)

11/01/11

Registrar

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

057952

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 9:22 M Daisy Pearl CASSIDY Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Meritus Medical Center Hagerstown Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Days Hours Min Maryland 1 M 2 T F Director 217-32-6152 1918 Usual Residence of Decedent 28a-f show 10a State 10b. County with the Maryland notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes X No Hagerstown Maryland Washington 9 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? must be Funeral 23a USA 21742 14014 Marsh Pike Page 1 and 2 should be filed within 72 hours after death \u00fanti of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items uny or other traumatic event, the Medical Examiner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. I Hygiene. I other than "natural", or iten vent, the Medical Examiner 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: White Specify Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16h. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Laundry Presser Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 0 Cora May Bivens Simon Cletus Younker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maugansville, Maryland 21767 P.O. Box 482 Dolores Thompson - Daughter 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H Important: If ite any injury or otl once. Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Cedar Lawn Mem. Park 11/8/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Ponermon. -Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Demen Sequentially list conditions, if any, leading to immediate cause. Enter orderlying Cause (Disease or iinjury (Rrebravasoniav Exami 410 burial-trans that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical death certificate be P.O. Box 68760 the as nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No jo Month Year 5 Other (specify) Day Pregnant at time of death signed by the a Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No After this certificate has 1 ☐ Yes 2 ☐ No • Hospital or Attending Physician; 24 hours after death. Funeral Director: After this certifical 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury Natural 5 Pending work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 706039 C 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) muns ARIN 21742 8 MD

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Paul Christy October 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 41255 Christy Lane Mary's

9. Birthplace (State or Foreign Mechanicsville 8. Date of Birth **Funeral** Social Security Number 7. Age (In yrs. last birthday) 1 **X** M 2 □ F Days Hours Month, Day. 1940|Pennsv1vanja Yrs Director 289-34-7569 Usual Residence of Decedent th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland St. Mary's <u>Mechaniçsville</u> 10e. Street and Number 10g. Citizen of What Country? Funeral 41255 Christy Lane 20659 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th. Local 5 Union Iron Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) t. Page 1 and 2 should be file rtment of Health and Mental I rtant: If item 27 is marked o ည Ralph E. Christy Cora_Brunton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elaine Christy/ Wife 41255 Christy Lane, Mechanicsville, MD. permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other 1 once. 20659 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) November 2, 2011, Cheltenham, MD Marvland Vets Cem. 21. Signatur of Vun∯ral Service Lincensee Huntt Funeral Home 22. Name and Address of Facility 3035 Old Washington Rd. Waldorf, MD Mollao 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Phylician/ CERKBROVASCULAR ACCIDENT disease or condition 3 WKS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No ď Day Year Pregnant at time of death ed by the a 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, CITACINOMA OF 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown To Be Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? has performed 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 \square Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20014168 11 Baner 10-31-11 Mount

State Registrar ROBERT

31. Date filed (Month, Day,

ODC

29103 THREE Notch Rd, MECHANIESVIlle Ind 20659

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

J. BAUKA, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0ct 31 7:15AM Gertrude Lesia Carrion Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Residence--8001 Madan Road, Prince George's 9. Birthplace (State or Foreign . Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday) Funeral (Month, Day, Year) Months Hours Country) 1 🗆 M 2 😾 F 71 Director 04-14-1940 092-32-1763 Brooklyn Usual Residence of Decedent or 28a-f shov 10c. City, Town or Location 10d, Inside City Limits 10a. State 10b County Director Examiner must be notified 1 X Yes 2 No MD Prince George's Greenbelt 10f. Zip Code 10g, Citizen of What Country? 10e. Street and Number 23a U.S.A. 8001 Madan Road, #104 20770 items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Year or Dates. 14 Race - American Indian 1. Marital Status Black, White, etc. or 1 Never Married 2 Married þ 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black "natural", Completed 3 Widowed 4 XXDivorced traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Je filed with:

-+al Hygiene.

--ar than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Health Care Clerical Administration marked other 12th Grade 17. Father's Name (First Be 18. Mother's Name (First, Middle, Maiden Surname) st. Middle, Last) should be file and Mental F is marked o ည Robert Victoria Johnson Reese 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1 and 2 s of Health a item 27 Kevin L. Carrion—Son
20a. Method of Disposition Greenbelt, MD 7923 Madan Road, 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) permit. Page 1. Department of Important: If it any injury or or 1 🗆 Burial 2 🗓 Cremation 3 🗀 Removal from State 11-05-2011 LEE CREMATORY CLINTON, MD 4 Donation 5 Other (Specify) 21. Signature of Euroral Service Licensee 22. Name and Address of Facility * Pinckney-Spangler F.H. 524 - 8th Street, N.E. Wash. DC 20002-5236 Part 1. Enter the disease, or complications that caused the death. Do r enter the move of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Prysician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying burial-transit Cause (Disease or initiary that initiated events resulting in death) Last signed by the attending physician I be detached for use as the buria Physician/Medical death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? Day Year Month 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, cate has been si ; page 2 should I 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 X or Attending Physician; The this certificate 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, 8 Hospital Other: 1 ☐ Yes 2 ☐ XNo မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 XNatural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 24 hours after death Funeral Director: / the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after de

To the Funeral Directo

completed filled in by th 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Muemp

Registrar

31. Date filed (Nobnth, Day, Year NOV 0 4 201

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State

3001 S. Hanover St.

32. Registra Signar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ heo dove Month 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Howard County General Hospital Columbia If Under 1 Year | If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth **Funeral** (Month, Day Year) eb. 24, 1952 North Carolina Days 1 X M 2 U I Months Hours Min. **Director** 577-72-1432 59 Usual Residence of Decedent 28a-f show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Washington DC 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 4551 Dix Street NE 20019 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc. "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give 1 ☐ Yes 2 No Specify: Completed 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Government Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Annie Mae Caudle Willie Fobbs Jr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4549 Dix Street NE Washington, DC 20019 Annie M. Brighthaupt - Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Nov. Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Brentwood, Maryland 2011 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Stewart Funeral Home, LIWE 20019 Benning Road NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician. disease or condition resulting in death) neart Congestive Medical Due to (or as a consequence of): Examiner myocardin Six portially list our flicks Examine if any, leading to immediate cause. Enter Underlying a Thenordans tre To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury nding physician and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ atten for u in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Pregnant at time of death ed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed to should be det 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed Pulmonary embolism 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Prectioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

30. Name and address of person who completed fause of death (Item 23a) (Type, Print)

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31,2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / State of Maryland / State of Maryland / Per / Stat	Department 27,68720 And I Certificate of Death	lental Hyglet Reg.	ne 2011 36968
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia Medic		Terry Lee DOMER, II		NOVEMBER	Day Year 945 PM
Stone	Examin		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
may have	Funeral		Meritus Medical Center 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	Hagerstown thday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Washington 9. Birthplace (State or Foreign
11-7	Director		220-78-5002 1 M ≥ □ F 38	Yrs. Months Days Hours Min.	Nov. 19 1	972 Maryland
	nd how at	٦	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow	n or Location		10d. Inside City Limits
	narylar Ba-f s tified	Director	Maryland Washington Clo	ear Spring		1 ☐ Yes 2🏋 No
	a or 2 be no	١	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
	th witl ms 23 must	Funeral	12402 St. Paul's Road	21722	ogifu Van or No	USA
21215-0036	within 72 hours after death with the Maryland glene. er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	11. Marital Status 1 🕅 Never Married 2	13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 X No Specify:	Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White
5-0	2 hour "natu edical	plet	15. Decedent's Education 16a (Specify only highest grade completed)	. Decedent's Usual Occupation (Give kind of work done during most of work	ing 16k	b. Kind of Business Industry
121	1 and 2 should be filed within 72 hour if Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical	Completed	Elementary/Seconday (0-12) College (1-4 or 5+)	life. DO NOT use retired) None		None
Dd 2	filed w al Hygi d othe	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Maid	
Maryland	should be file n and Mental I 7 is marked o raumatic eve	T ₀	Terry Lee Domer, Sr.	Regina 3	Tane Malot	t
Maı	2 shoul th and I 27 is m traum		Hocher	o. Mailing Address (Street and Number or Rur 2402 St. Paul Road, (_	
ē,	1 and 2 s of Health item 27 i	1	20a. Method of Disposition 20b. Place of	of Disposition (Name of ery, crematory or other place)		c. Location - City or Town, State
imo	nit. Page lartment o ortant: If injury or		A Burial 2 - Cremation 3 - Removalifon State	Lawn Mem. Park 11/9	/2011 Ha	gerstown, Maryland
Baltimore,	permit. Page 1 a Department of F Important, if ite any injury or ot once.	VO.	21. Signature of Funeral Service Licensee	22. Name and Address of Facility Mir 415 E. Wilson Blvd		
			23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between
Water .	Physician/ Medical	13	Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence	NIR C	1 M Sugar	Approximate Interval Between Onset and Death
	Examiner		Conch	ral Palsy CER	THE CATION APPROVED	
	7 #	iner	Sequentially list conditions,			
	ecutec and I-trans	Examiner	Cause (Disease or iinjury that initiated events resulting in death) Last C. Due to (or as a consequence	of:	INJUN	7
0	cate be executed physician and s the burial-transit	edical 1	Restrictive	armatic Orain	vated rig	ght Diaphram
876	ificate ng phy as the	Med	IF FEMALE:			
Box 68760	that the death certifice ned by the attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery Month Day Year
	the de by the achec	hysi	9 Unknown			
ds, P.O.	v requires that s been signed k should be det	δ	Part II. Other significant conditions contributing to death but not resulting		23e. Did tobac	co use contribute to the cause of death?
Division of Vital Records,	The lav	Completed			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death? No 1 Yes 2 No
ital	ysician: is certific director,	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec		
of V	ding Phys th. After this funeral di	e: To	Adams Bar Varia	Time of 28c. Injury at		e 6 Other (Specify) injury occurred Subject
on	Attending or death. ector: After by the fune	Certificate:		injury work? known M 1 ☐ Yes 2 X No		n struck by a car
ivis	اء ﷺ ق		4 Homicide determined 28e. Place of Injury - At home, fi building, etc. (Specify)	arm, street, factory, office	28f. Location (Stree City or Town, S Hagerstow	at and Number or Rural Route Number, state) Maryland Avenue
	To the Hospital or Attend within 24 hours after deat! To the Funeral Director, completed filled in by the	Medical	29a. Certifier (Check (Check and yours) Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/	or investigation, in my opinion, death occurred a	nd due to the cause(s at the time, date and p	s) and manner as stated. blace, and due to the cause(s) and manner stated.
	To the within To the comp	2	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
			> Found miled	D06039	63	11/07/11
1	W-Z		30. Name and address of person who completed cause of death (Item 23a)	(Type, Print) 11 7 6 0 f a	noter t	MD 21742
	Stat Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	born		

Dashington

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 - For State of Maryland / Dep	artment of Health and Nertificate of Death		2011	36969
			Decedent's Name (First, Middle, Last)		2. Date of Death	Day Year	3. Time of Death
	Physici		James Leroy Dowell		October	29 2011	4:45 A M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	h
			6450 Solomons Island Road	Sunderland		Ca1v	ert
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	(ear) 9. Birt	hplace (State or Foreign untry)
	Director		216-18-5729 ¹ \(\Pi\) M 2□ F 90 Yrs.	Months Days Hours	12-08-19	20 Mar	yland
	D >		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or I	ocation			10d. Inside City Limits
	sho	'n					1 ☐ Yes 2 No
	Ne M	Director	MD Calvert	Sunderland 10f. Zip Code	100	. Citizen of What Co	untry?
	with t			32	100	USA	and y
	eath re 23	Funeral	6450 So1omons Island Road 11. Marital Status 12. Was Decedent Ever in U.S. 13	Was Decedent of Hispanic Origin? (Sc	ecity Yes or No-	14. Race - Ame	nican Indian,
	itam itam	ů.	1 Never Married 2 Married 1 M Yes 2 No	Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	e, etc.
3	urs af	by	1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates: 1946-47	1 ☐ Yes 2 🕅 No Specify:		Specify: Wh	ite
5	2 hor	Completed	15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	3b. Kind of Business	Industry
<u>,</u>	hin 7	ple	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	urg		
1	od with	Con	9 Far			Agricultu	re
2	at Hy at Hy d oth	Be (17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Ma		
<u>x</u>	Ment Ment arke	2	James Albert Dowell	Bertha		Turner	
<u> </u>	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or itame 23a or 28a-f show is marked other than "natural", or itame 23a or 28a-f show aumatic event, the Medical Examiner must be nutilised at			ling Address (Street and Number or Run			Zip Code)
2	and lealth m 27 her t			Box 36, Sunderlan		0689 Oc. Location - City or	Town State
5	ges If of I		1 🕅 Burial 2 □ Cremation 3 □ Removal from State cemetery, cr	ematory or other place)			
	t. Partmer rtant					Sunderland	
ā	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healih and Mental Hygiene. Department of Healih and Mental Hygiene. Department of Healih and Mental Hygiene. Department of Healih and Mental Hygiene. Department of Hygiene Trianmatic event, the Medical Examiner must be notified at once.			325 Mt. Harmony La		neral Home	· ·
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e				Approximate
			shock, or heart failure. List only one cause on each line.				Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death) a. HTIEYOSCIERO Due to (or as a consequence of):	otic Cardiova	ycular i	cu rease	
	Examiner		Due to (or as a consequence of).				
		ler	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):				
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events c.				
ĵ	an ar rial-ti	Ex	resulting in death) Last Due to (or as a consequence of):				
,	cata be executed physician and the burial-transit	dical					
5	ng ph ng ph as t	Med	IF FEMALE:				
ל כ	ath ce ttendi	an/	23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3	□Ectopic pregnancy		23d. Date of de Month	livery Day Year
	the a	Physiclan/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5	Other (specify)			
	hat th od by detac		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute t	o the cause of death?
מכסומא,	w requires that the death certific been signed by the attending p should be detached for use as	d by	Candia my a pather		1 □ Yes	2 No 3 P	robably 4 Unknown
5	w requir been si should	etec	End Stage Deme	24/6	24a. Was an	24h Were a	utopsy findings available
ב	has has ge 2 t	Completed	end stage Dervie	11919	autopsy perform	ed? prior to death?	completion of cause of
A II a	n: Th ficate n, pa		25. Was case referred to medical	00 81		4110	s 2□ No
=	sicial	o Be	examiner? 1 □ Yes 2 No Hospital: 1 □ Inpatient 2 □ ER/Outpati	Other	th (Check only one	nce 6 □Other (Spe	acity)
5	Phy or this oral d	l-m	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe hov		, only ,
5	afth. :: Afte	atloi	1 Natural 5 □ Pending (Month, Day Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
10101	Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or R	tural Route Number,
5	s after sale or all Dir	Cert	Paliding, etc. (Specify)		, , , , , , , , , , , , , , , , , , , ,		
	To the Hospital or Attending Physician: The law requires that the death certificata be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only (Ch	ath occurred at the time, date and place investigation, in my opinion, death occu	, and due to the car rred at the time, da	use(s) and manner a te and place, and du	s stated. e to the cause(s)
	thin 2 the I	Med	one) and manner stated.				
	7 × 7 8		eyon c swong	7 5065	3	11-1-	2011
	\		30. Name and address of person who completed cause of death (Item 23a) (Typ	a Print\		•	
λf	15+1		29b. Signature and title of certifier Surrono 30. Name and address of person who completed cause of death (Item 23a) (Typ 5 8 5 1 - Decile Church to V. 31. Date filed (Month, Day, Year) 32. Registral's Signature	Road Dea	re m	D 20	751
	Sta	ite	31. Date filed (Month, Day, Year) 32. Registral's Signature	,			
	Registr	rar	NUV - 2 2011 Denus B	Lacked .			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
 Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 8:55 A Frances Terese Durrah October . Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Prince George's Southern Maryland Hospital Clinton Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Hours Director 111 18 3924 1 🗆 M 2 🗶 F 87 Oct 28, 1924 New Jersey Usual Residence of Decedent an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 Yes 2 No District heights Prince George's Maryland 10a. Citizen of What Country? 10e. Street and Number Funeral United States 20747 6603 Atwood Street within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 Never Married 2 Married 1 Yes 2 XXNo δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2XX No Specify: Specify: Black 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) the Homemaker Own Home 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) and Mental F is marked o ဂ္ Mabel Shelly Major Steves Cowin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health ar Important: If item 27 is any injury or other trau 6106 Hope Drive, Temple Hills, MD 20748 Regina Ross (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nov 12, 2011 Lee Crematory Clinton, MD 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexan ris Signature of Funeral Si Ferry Road, CLinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underhin Cause (Disease or injury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events Due to (or as a consequence of): resulting in death) Last ed by the attending physician detached for use as the buria Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 1 Yes 2 9 Unknown 2 No s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? KIDNEY DISEASE 1 Yes 2 No 3 Probably 4 Unknown OBSTRUCTIVE PULMONARY 24b, Were autopsy findings available 24a. Was an prior to completion of cause of death? has director, page 2 performed? SEASE 1 ☐ Yes 2 ☐ No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA completely filled in by the funeral Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 28c. Injury at within 24 hours after death.

To the Funeral Director: After Natural Natural 5 Pending work 1 Yes 2 No Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ATTEN DING PHYSICIAN

DCD

State N Registrar

MUSA MOMOH M
31. Date filed (Month, Day, Year)

NOV 02

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

) 12150 ANNAPOLIS ROAD, HZUS, GLENN DALE MD 20769
32. Registrar's Signature

barker

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar 3697 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ october 31, 2014 11:21 a M Anthony George D'Adamo Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Carroll Westminster 30 W. Green Street, apt 3 If Under 1 Year If Under 24 Hrs g Birthplace (State or Foreign) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** ^{Year)}19<u>53</u> New Jersey Months Days Hours June 27 58 152-44-9669 Director Usual Residence of Decedent 10d. Inside City Limits 28a-f shov 10h County 10c. City, Town or Location 10a. State filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f shor Examiner must be notified at Director Westminster 1 X Yes 2 □ No Carroll Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21157 30 W. Green Street, apt 3 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11 Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black White etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: white "natural", Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l. Department of Health and Mental Hygiene. Important: If item 27 is marked other tran "na any injury or other traumatic event". College (1-4 or 5+) Elementary/Seconday (0-12) Cleaning Service Self Employed 12 Be 17. Father's Name (First, Middle, Last)

Almond D'Adamo 18. Mother's Name (First, Middle, Maiden Surname) Gertrude Applegate 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1020 McGlaughlin Road, Fairfield, PA 17320 James Schumacher, cousin 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) All Faiths Crematory 11/02/2011 Manchester, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Name and Address of Facility Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death UDGE CLASTEDINTESTINAL Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** VAROLES COOMACICA Sequentially list conditions, Due to for as a consequence of) cause. Enter Underlying Cause (Disease or linjury the attending physician and hed for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed (a or HOSI) that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical neosthi Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ☐ Live Birth ∠ ☐ , o.... ☐ Pregnant at time of death in the past 12 months? Month Year 2 🗆 No After this certificate has been signed by the a funeral director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Disbetes 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 HO 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ᅆ 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 Pending after death.

Director: Afted in by the fundament 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide City or Town, State) 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D 43643 31 WJL 3 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

Frederick St

mo

32. Registrar's Signature

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TANGUTOUN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Jane Drucilla FAULDER November 2011 5:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death
Washington Reeder's Memorial Home Boonsboro 5. Social Security Number Funeral 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 🗆 M 2 🕱 F Months Days Hours Nov. Pay, Year 1922 219-20-1774 88 **Director** Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location must be notified at Director 10d, Inside City Limits Maryland Washington Boonsboro 1 Yes 2x No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21713 U.S.A. 21441 Ruble Road 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. white þ 1 Never Married 2 Married and 2 should be filed within 72 hours after Health and Mental Hygiene. 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) traumatic event, the department store service department manager 10 marked other Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mildred G. Springer ပ Clarence A. Cosens 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21151 San Mar Road, Boonsboro, Maryland 21713 2 Health a Barbara Rhodes - Daughter per it. Page 1 and 2: Decartment of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Hagerstown Crematory ☐ Burial 2 X Cremation 3 ☐ Removal from State November 7, Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Minnich Funeral Home 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death
I-2 Diyys Immediate Cause (Final disease or condition Physician/ Chronie 0 55hru Medical resulting in death) Examiner stage Y carris Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of). CONGESTIVE 148AR Due to (or as a consequence of) the attending physician Hospital or Attending Physician: The law requires that the death certificate be CHRONIC YEARS ATROM Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 No Yes 1 Yes Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 28d. Describe how injury occurred Matural Natural work? iniury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d, Date signed (Month, Dav. Year) 146561 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20311 Lappans Road, Boonsboro, MD TW-5 Ghazala Qadir 21713 301-432-8470 31. Date filed (Month, Day,

DHMH 17 Rev 7/2009

State

Registrar

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Faulder

Registrar's Signature

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 7 October 201 Physician/ 5:48p M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner Charles Civista Medical LaPlata Center 8. Date of Birth (Month, Day, Ye March 15 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Age (In yrs. last birthday) 5. Social Security Number **Funeral** Washington D.C 1 → M 2 □ F 219-86-8877 48 1963 Director Usual Residence of Decedent 10d. Inside City Limits th and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 Yes 2 No Maryland Charles Bryans Road 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 6709 Amherst Road 20616 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 🗌 Widowed 4 🗌 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Company Escavator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Vivian Goodin permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic Henry Lee Freeman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6709 Amherst Rd, Bryans Road, Md. 20616 Wife Ileen T. Freeman 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Nov. 5, Date 2011 ☐ Burial 2 XCremation 3 ☐ Removal from State Alexandria, Virginia Metropolitan Funeral Service 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Lic WilTiams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Part 1. Enter th Interval Between Onset and Death shock, or hear failure. List only one cause on each lin Immediate Cause (Final disease or condition Physician Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events ng physician and as the burial-tran resulting in death) Last the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery for use 23b. Was decedent pregnant Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ Month Dav Year in the past 12 months? Pregnant at time of death Yes 2 No 9 Unknown g Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of do th? Part II. Other significant conditions contributing to death but not resulting in the underlying sause given in Part I. Completed by 4 V Unknown 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy has erformed? certificate 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 17 No Inpatient 2 ER/Outpatient 3 DOA 1 Yes မ this 27. Manuar of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 24 hours after deal Funeral Director: 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 🗌 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 To the I only one 29d. Date signed Month. Dav. 29c. License numbe 29b. Signature 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) DC 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2:00 P M Donald Lee GROVE, Sr. Nov 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Williamsport Williamsport Nursing Home Washington 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under **Funeral** (Month, Day, Days Hours Min West Virginia 1 X M 2 🗆 F Months Oct. **Director** 214-28-6009 80 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits notified at 10c. City, Town or Location Director 1 ☐ Yes 2X No Maryland Washington Hagerstown ō 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be Funeral 44 Village Lane 21740 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Black, White, etc. à 1 Never Married 2 Married ☐ Yes 2 X No Maryland 21215-0036 ner than "natural", (; the Medical Exam If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 X Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working I Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 0 Grocery Store <u>ssistant Manager</u> traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be file, and Mental H is marked ot ည Leslie Grove Velet Strobridge 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau <u> Victoria White - Daughter</u> Tisa Lane, Pottstown, Pa. 19465 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20h Place of Disposition (Name of Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Hill Cemetery 11/7/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licens 22. Name and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) and -transit Exami Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last physician a the burial-Medical Box 68760 attending p IF FEMALE: Physician/ 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Month Pregnant at time of death 2 No 1 Yes 2 L the Unknown Division of Vital Records, P.O. á signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown has been sig ge 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ျပ Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural iniury work? 5 Pending 2 🗌 No after death. 2 Accident
3 Suicide Investigation Funeral Director; eted filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 24 (Check within 2 To the I ~3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 21742 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Northern Am 580

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month,

32. Pagistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 58M Month Gary Allen HUNTSBERGER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Meritus Medical Center Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Yea Aug • 28, . Social Security Number 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign **Funeral** Hours 1 X M 2 □ F 1937 Penna **Director** 177-30-7504 74 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If teem 27 is marked other than "natural", or items 23a or 28a-f sho important: If teem 27 is marked other than "natural", or items be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Completed by Funeral Director 1 ☐ Yes 2X No Maryland Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 177 Stanford Road 21742 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Never Married 2 X Married 1 K Yes 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white 3 Divorced 4 Divorced Year or Dates. 1955-59 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) union stewart trucking 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Corine E. Greenawalt Bruce A. Huntsberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 177 Stanford Rd., Hagerstown, Maryland 21742 Sandra Huntsberger - wife 20c. Location - City or Town, State 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 A Cremation 3 Removal from State 11/8/11 Hagerstown Crematory Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Frieral Service Lice 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Hospital or Attending Physician: The law requires that the death certificate be executed (OTONAZI sate has been signed by the attending physician and page 2 should be detached for use as the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? After this certificate 1 ☐ Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at Natural injury work? 5 Pending Accident Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basic of examination and/or inventigation in my color 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check

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m 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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vieugai Examir		4a. Facility Name (if not institution Frederick Memorial H		<u>Jackson</u>		4b. City, Town, o	or Location of		er 10, 2011 4c. County o Fredericl		
Funeral Director		5. Social Security Number 531-54-4521	6. Sex	7. Age (In yrs. I 58	ast birthday) Yrs	If Under 1 Ye Months Da		Min	19, 1953	Foreign	
Maryland 28a-f show any d at once.	Ī	Usual Residence of Decedent 10a. State 10b. County aryland Prince			Town or Local		ollege	Park			10d. Inside City Limits 1 X Yes 2 No
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21215-0036 hould be filed within 7 and Mental Hygiene. is marked other than attic event, the Medica	To Be	19a. Informant's Name/Relations	lbert Jack ship(Type, Print)		4.		et and Numb	oer or Rural Route No	n Davis umber, City or Town	n, State,	
Baltimore, MD 2121; permit. Pages I and 2 should be fill Department of Health and Mental F Important: If item 27 is marked injury or other traumatic event, i		Annie J. Sprigg 20a. Method of Disposition 1 Burial 2 Crematio 4 Donation 5 Other S	n 3 Removal fr	20b.	crematory or ot Mt. (herplace))livet		Nov. 21, 2011	Washi	ingt	and 20740 Town, State
	-	21. Signature of Funeral Service	Stenk	1	40	001 Benn	ing Ro	Stewart F	shington	, DC	
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S, P.O. E uires that the d	[출	Part II. Other significant condi	tions contributing to	o death but not r	esulting in the	underlying cause	given in Par		res 2 ✔ No 3	Prob	the cause of death? ably 4 Unknown topsy findings available
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To the Hor within 24 h To the Fu	Medical	(Check only one) 2 Medical Example 29b. Signature and title of certific	aminer: On the basis and manner s	of examination a	and/or investiga	29c. Lice	on, death occ	curred at the time, da	te and place, and o	ed (Mor	e cause(s) nth, Day, Year)
12		30. Name and address of person Donna M. Vincenti, M					c.M.E. re Street,	Baltimore, MD 2	November 21223	10, 20	
Sta Regist	ate							· · · · · · · · · · · · · · · · · · ·			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Year Brenda Kay Knott 0407 AM 201 NOVEMBER Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Meritus Medical Center Washington Hagerstown 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday) Hours March 10. Illinois **Director** Yrs 357-40-9930 64 Usual Residence of Decedent 28a-f show 10a. State 10b. County be filed within 72 hours after death with the Maryland item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 ¥ Yes 2 ☐ No Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Be Completed by Funeral 34 Elizabeth St. 21740 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc. 1 Never Married 2 X Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 th and Mental Hygiene. Elementary/Seconday (0-12) 12 th College (1-4 or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Samuel Wayne Bledsaw Jeanette Ilene Miller if, Page 1 and 2 shou... of Health and Me or 27 is mr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 2; any injury or other tonce. / Husband <u>Rodney J. Knott, Sr.</u> Elizabeth St., Hagerstown. MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 🗆 Burial 2 🗷 Cremation 3 🗀 Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematorium 11/5/2011 Smithsburg, Maryland Signature of Funeral Service Licenses 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betweer shock, or heart failure. List only one cause Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) nous 1a Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 Yes 2 No Year Month Day Other (specify) Pregnant at time of death 1 Yes 2 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No 24a. Was an page 2 s autopsy performe certificate Yes 2 7 director. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 \(\sum \) Yes within 24 hours after death. To the Funeral Director: After to ompleted filled in by the funer. 28d. Describe how injury occurred Natural Accider 5 Pending injury 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

IN-6 State Registrar

the Hospital

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day

npleted cause of death (Item 23a) (Type, Print) 68

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

365

29d. Date signed (Month, Day, Year)

Hagesbau MD21740

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death docurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death Physician/ Month Day 1350 PM ecra October noma 2011 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Hospital Cambridge Dorchester orchester General 5. Social Security Number If Under 1 Year Munder 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 X M 2 - F Hours 5-36-04 Director Maryland items 23a or 28a-f show 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Director Examiner must be notified 1 Wes 2 No ambrid 10e. Street and Numbe 10f. Zin code 10g. Citizen of What Country? Funeral AVe, Greenwood 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 20 \$ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Projvorced Black the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation. 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Seafood Department of Health and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) orge 19b. Mailing Address (Street and Number or Rural Route Number, City of 19a. Informant's Name/Relationship (Type, Print) Town, State, Zip Code) Anderson e, MD. Joanne Baltimore, 20a. Method of Disposition
1 🖸 Burial 2 🖸 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City Town, State Date Page 1 Cemetery Bethel 4 ☐ Donation 5 ☐ Other (Specify) ambrid permit. I Signature of Funeral Service Licensee Name and Address of Facility enry funeral MD. 21613 ington 23a. Part. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Priysician/ disease or condition years Medical resulting in death) Examiner eass Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical that the death certificate be use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? for Month Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe Records, or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Sevordary hyper pasalty roudion 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed? death? certificate 1 Yes 2 No Yes 2 director. 25. Was case referred to medical **Division of Vital** To Be 26. Place of Death (Check only one) examiner? 2 🖳 No Other: 1 🗌 Inpatient 2 🗷 ER/Outpatient 3 🗌 DOA 4 Nursing Home 5 Residence 6 Other (Specify) this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination arrows investigation, if my specific and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 0 29c. License number 29d. Date signed (Month, Day, Year) 00 46020

Registrar

State

Dutchmans Lane,

21601

MD

Easton,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D

505A

Syed Ishrat Ali,

31. Date filed (Month, Day, Year)

NOV 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Edward Lewis, 2 2011 2:45 November Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 1 M 2 □ F Months Days Hours Min 5 /6"/ 19 26 217-30-7826 85 Director Yrs MD Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits 1 Yes 2X No Worcester Berlin 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 100 Ann Drive 21811 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces? 1X☐ Yes 2☐ No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: white Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha 9 Truck Driver Perdue Be Page 1 and 2 should be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sewell Lewis Mildred Rodney permit. Page 1 and 2 should Department of Health and M Important: If item 27 is man any injury or other traumat 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 Ann Dr., Mae Randall Lewis wife Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 X Burial 2 Cremation 3 Removal from State Evergreen Cemetery 11/5/11 Berlin, MD 4 ☐ Donation 5 ☐ Other (Specify) 21, Signature Service License of Funer 22. Name and Address of Facility Burbage Funeral 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that ca used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on e Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Lisease of imjury law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death led by the a detached f 9 Unknown 9 Unknown eral Director: After this certificate has been signed filled in by the funeral director, page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\subseteq \text{ Yes} \) 2 \(\subseteq \text{ No} \) 24a Was an autopsy performed? Yes__2 A No certificate or Attending Physician; Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) er death. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28b, Time of Certificate: 28d. Describe how injury occurred 5 Pending 1 XNatural injury Accident
Suicide Investigation 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after of To the Funeral Direct completed filled in by 28f. Location (Street and Number or Rural Route Number. City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Dedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Example 2 Descripting Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature au d title of certifier

BA3+1

State Registrar

Pennie Savage, CRNP 31. Date filed (Month, Day, Year) NOV 03

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9715 Healthway Dr., Berlin, Registrar's Signature

R 135131

29d, Date signed (Month, Day, Year)

November 2,

2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	Otate of Mai	-	Certificate of D			•	2011	36981
	Physicia	in/	1. Decedent's Name (First, Middle, Las	,				2. Date of Dea Novemb		$20\overset{\mathrm{Year}}{1}$	3. Time of Death
	Medid Examin		Barbara Ann 4a. Facility Name (if not institution, give			4b. City. Town, or	Location of Death	Novemb		2011 ounty of Death	12:45 P M
			7783 Dentzell Cou	rt			ake Beach		- 1	Calver	
1	Funeral Director		5. Social Security Number 6. So	DAA O XI E	n yrs. last birtho		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day)		g. Birth Coul	place (State or Foreign ntry)
100			479-40-4986 Usual Residence of Decedent		73 ^Y	13.		02-17-	1938	Ohio)
	yland -f sho ed at	ctor	10a. State 10b. County	1	0c. City, Town	or Location					10d. Inside City Limits
:	ie Mar r 28a notifi	Director	MD Calvert 10e. Street and Number			Chesape	ake Beach				1 🕅 Yes 2 🗆 No
:	with the 23a cast be	Funeral	7783 Dentzell Cou	rt			732		10g. Citize	en of What Cou USA	ntry?
	death items ner mi		11. Marital Status	12. Was Decedent Eve Armed Forces?	r in U.S.	13. Was Decedent of Hi If Yes, specify Cuba		cify Yes or No-	14	. Race - Ameri	
36	I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Health and Mental Hygiene. The marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	d by	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2 🛣 No		ilouii, oto.,	Sp	Black, White, pecify:	
<u> </u>	hours natur jical E	olete	15. Decedent's Ed	Year or Dates.	16a. C	Decedent's Usual Occupa	ation	- 1		Whi of Business In	
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Baltimore, Maryland 21215-0036	ed wit Hygie other ent, th	Be C	17. Father's Name (First, Middle, Last)	4	Ca:	rtographer 	18. Mother's Name	/Eirst Middle I			vernment
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lary	should and N is ma auma		19a. Informant's Name/Relationship (Ty		19b. I	Mailing Address (Street a					Code)
ა ი	and 2 s Health em 27 ther tra		Warren G. La Heis	t, Sr., Spo			1 Court,	Chesape			
JOE .			20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	cemetery,	Disposition (Name of crematory or other place	9)	ate		ation - City or T	
iti Ti	permit. Page Department Important: If any injury or once,		4 Donation 5 Other (Specify 21. Signature of Funeral Service Licens		Metrop	olitan Crem					
ñ	permit. Departr Imports any inju		I William R.		100715	8325 Mt.	- Ita	usch Fu ane. Ow		•	
П			23a. Part 1. Enter the disease, or comp shock, or heart failure. List only or	lications that caused the	e death. Do not						Approximate Interval Between
P	hyrician/ Medical	ÿ 72	Immediate Cause (Final disease or condition	. Ovar	ian (concer					Onset and Death
ment E	Examiner		resulting in death)	Due to (or as a co	onsequence of)	:					
		iner	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a co	onsequence of)	:					
to the	nd	Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events	C						1	
8/60 ificate he executed	physician and s the burial-transit	al E	resulting in death) Last	Due to (or as a co	onsequence of)	:					
3/60 Figste b	ig phys	Medical		d							
O a	ending use a		and a cood of the programme	23c. If yes, outcome of p	oregnancy	3 Ectopic pregnance	,		230	d. Date of deliv	ery
BOX 6	h. After this certificate has been signed by the attendin funeral director, page 2 should be detached for use	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 Pregnant at tir		5 Other (specify)	,			Month	Day Year
7 ±	ed by detacl		Part II. Other significant conditions co	ntributing to death but r	not resulting in t	the underlying cause give	en in Part I.	23e. Did tol	pacco use	contribute to t	he cause of death?
	n sign	ed by						1 🗆 Y	es 2 🔀	No 3 🗆 Pro	bably 4 🗆 Unknown
Mecords,	as bee 2 shoi	Completed						24a. Was a		24b. Were auto	psy findings available impletion of cause of
בֿ פֿ ב	cate h	Con						perform 1 Yes	med?	death?	
Vital	certifi	m	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑No	lospital:		Otho	ce of Death (Check				
	er this ieral di	ie: To	27. Manner of Death	28a. Date of injury	28b. Tim	patient 3 DOA DOA 28c. Injury	4 Nursing Hon	ne 5 🔀 Reside 8d. Describe ho			/)
on endin	eath. or: Aft the fur	Certificate:	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	(Month, Day, Ye	e <i>ar)</i> inju		Yes 2 No				
DIVISION Tal or Attendir	within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral director,	Cert	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - building, etc. (S	- At home, farm Specify)	, street, factory, office	2	8f. Location (St City or Town		lumber or Rura	Route Number,
soital C	neral I filled	ical	29a. Certifier 1 A Certifying Phys	cian: To the best of my	knowledge, de	ath occured at the time,	date and place, and	due to the cau	se(s) and n	nanner as state	ed.
he Ho	nin 24 the Fu	Medical	(Check 2 Medical Examin	er: On the basis of exam	ination and/or in	nvestigation, in my opinion	death occurred at t	he time, date an	diplace an	nd due to the ca	use(s) and manner stated
- P	To To		29b. Signature and title of certifier			29c. License	number	2	9d. Date s	signed (Month,	Day, Year)
		-	Matter and address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same address of the same	e MD	/ltor- 00 \ T	DOOS	7061		150	vem be	1 4,2011
JRW)	12		30. Name and address of person who co	IIO 1765 6	1 +20 (Typ	Rd, Pri	nce Fre	den	CK	MI	Day, Year) 2,2011 20678
	Stat	٠,	31. Date filed (Month, Day, Year)	32. Registro	Signature	6 1					
	Registra		NOV -	27017 Cler	was ,	J. Darke					

JORDAN LEHMAN NOVEMBER S,2011 2110 Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Hospital or Attending Physician: The law requires that the death certificate be executed.

	_	For State of M State of M Registrar	-	artment of Hea rtificate of Dea	Ith and Mental Hyg th	giene Reg. No. 201	1 3698
hysiciar Medica		1. Decedent's Name (First, Middle, Last) Jordan Robert Lehman			2. Date of Dea Novembe		3. Time of Death 21:10 M
Examine		4a. Facility Name (if not institution, give street and number) Shady Grove Adventist Hos	pital	4b. City, Town, or Loca Rockville	ition of Death	4c. County of De Montgome	ery County
uneral rector		$ \begin{array}{cccccccccccccccccccccccccccccccccccc$	ge (In yrs. last birthday) 10 Yrs.		urs Min. 8. Date of Birt (Month, pa		irthplace (State or Foreign ountry) iry Land
28a-f shovotified at	irecto	Maryland Calvert County	10c. City, Town or Lo Prince Fr	ederick			10d. Inside City Limits 1 X Yes 2 □ No
ns 23a o	Funeral [10e. Street and Number 425 Rachel's Way		10f. Zip Code 20678		10g. Citizen of What C	Country?
o in	<u>ک</u>	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent I Armed Forces? 1 Yes, Give Year or Dates.	No	Was Decedent of Hispani If Yes, specify Cuban, Me 1 □ Yes 2 ሺ No <i>Sp</i>	c Origin? (Specify Yes or No- xican, Puerto Rican, etc.) ecify:	14. Race - Am Black, Wh Specify: Wh	ite, etc.
than "natu he Medical	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 8)	(Give	dent's Usual Occupation kind of work done during O NOT use retired)	most of working	16b. Kind of Busines	s Industry
arked other	To Be (17. Father's Name (First, Middle, Last) Robert Chester Lehman	IV/A		Mother's Name (First, Middle, A Acqueline L. F	Maiden Surname)	ın
m 27 is ma		19a. Informant's Name/Relationship (Type, Print) Robert C. Lehman-father	1	-	umber or Rural Route Number Prince Frede		
rtant: If ite ijury or oth		20a. Method of Disposition 1 ☐ Burial 2 💢 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Smithsbu	matory or other place) Irg Cremator		20c. Location - City of Smithsburg	g, MD
any ir		21. Signature of Funeral Service Licensee Nathanana Ac 23a. Part 1. Enter the disease, or complications that caused	to 1	.331 Eastern	Facility Douglas A. Blvd. North I	Hagerstown	neral Home , MD 21742
ici n edical miner miner	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Either Unuerlying Cause (Disease or injury that initiated events c.	1	eage			Interval Between Onset and Death
to the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of o	elivery Day Year
should be detached	۾	Part II. Other significant conditions contributing to death b	out not resulting in the t	underlying cause given in		obacco use contribute	to the cause of death?
page 2 should	Completed				24a. Was a autop perfor 1 🗆 Yes	rmed? prior to	uutopsy findings available completion of cause of
director,		25. Was case referred to medical examiner? 1 Dryses 2 No Hospital: 1 Inpati	ent 2 🏿 ER/Outpatie	Other:	Death (Check only one) ☐ Nursing Home 5 ☐ Resid	lence 6 🗆 Other (Spe	ecify)
the funeral	Certificate:	27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident Investigation 3 Suicide 6 Could not be	y, Year) injury	work? M 1 Yes	_ [ow injury occurred	
completed filled in by the funer		4 Homicide determined 28e. Place of Inju- building, etc			City or Tow.		
ompleted i	Med	29a. Certifier (Check 2 Medical Examiner: On the best of (check only one) 3 Certifying Nurse Practioner: To the 29b. Signature and title of certifier.	my knowledge, death xamination and/or inves best of my knowledge,	tigation, in my opinion, death occurred at the time,	and place, and due to the cau ath occurred at the time, date ar , date and place, and due to the	use(s) and manner as s and place, and due to the e cause(s) and manner a	e cause(s) and manner stat as stated.
: 8	ľ	David Fredra	MD	D00 6	ath occurred at the time, date are date and place, and due to the oper 3782 Rockville,	29d. Date signed (Mor	Nov 5, 2011
		30. Name and address of person who completed cause of d	eath (Item 23a) (Type. F	Print)		7	

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene																	
		_ State		Sta	ate of M	larylan		artment <i>rtificate</i>			and M	1ental Hy	•	21	1 1	1	369	3 8 3
		Registrar 1. Decedent's Name	e (First, Middle	, Last)				Tillicate	OI D	eaur		2. Date of De	Reg. I	No.	1		Time of De	
Physicia Medic		Willie	W	anda			L	aws				Novemb	oer '	³ , 2	o Ti		:23	Ам
Examin		4a. Facility Name (if			nd number)			4b. City, To					4	4c. County				
		11903 He 5. Social Security No		Drive 6. Sex	17.0	an Amarina I	ast birthday)	Ha If Under 1		If Under		0 Data of Bir	-41-	Was	hing			
Funeral Director		233-36-4	049	1 M 2	ME	92	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Pa	919	}			(State or F irgin	
show at	or	Usual Residence of 10a. State	10b. County			10c. Cit	y, Town or L	ocation								10d. lr	nside City I	Limits
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h the la or 2	Funeral Director	10e. Street and Num						10f. Zip (Code				10g.	Citizen of	What Co	untry?		
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or ite	by Fu	11. Marital Status1 Never Marri	ied 2 🗆 Mari	Arr	is Decedent ned Forces? 2 Yes 2		5. 13.	If Yes, specif	nt of His y Cubar	n, Mexica	n, Puerto	cify Yes or No- Rican, etc.)			e - Ame ck, Whit	rican Ind e, etc.	dian,	
ırs afte ıral", I Exar	ed b	3 Nidowed		If Y	es, Give ar or Dates.			1 Yes 2	No	Specify	:			Specify		ite		
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illed w Il Hygi I othe vent,	Be	17. Father's Name (F	First, Middle, L	.ast)			Home	manci		18. Moth	er's Name	e (First, Middle,		len Surname)				
ld be i Menta arked atic e	입	John Wil	lliam E	dwards						E	the1	Nelso	n					
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and 2 Health tem 2		Wanda Pi				20h F)3 Heat		Dri		Hagerst Date	$\overline{}$	Location			State	
ent of ent of nt: If it		1 ☐ Burial 2 4 ☐ Donation	Cremation		al from State		emetery, cre	matory or oth	er place								ary1a	nd
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		A	neral Service L	icepeed	XH I	lomi						st Have						iid .
B E E		Mul	2 M	- M	M.							ve., Ha						
Physician/ Medical		23a. Part 1. Enter the shock, or hear Immediate Cause (I disease or condition resulting in death)	rt failure. List o Final	only one caus		e.	tipl	ter the mode	of dying	, such as	cardiac d	or respiratory a	rrest,			Inter	oroximate rval Betwe et and Dea	ath
Examiner	iner	Sequentially list con if any, leading to im cause. Enter Under	nditions, nmediate	b. —	Due to (or as	a consequ	uence of):			<u>۔</u>					_			
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te be (nysicia ne bur	dical			d														
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Medica	IF FEMALE: 23b. Was decedent in the past 12 r 1 Yes 2	months?	1 [4 [res, outcome Live Birth Pregnant a	2 Feta	I death 3	☐ Ectopic pr☐ Other (spe		4					ite of de	livery Day	Yea	ar
es that the signed by i	d by Phy	Part II. Other signif		ons contributi	ng to death I	out not res	ulting in the	underlying ca	use give	en in Part	I.	23e. Did 1		1			use of dear	
law requi has been je 2 should	mplete											24a. Was auto		24b.	Were au	itopsy fii	ndings ava	ailable
n: The ificate or, pag	e Co	25. Was case referre	ed to medical			-			26 Dia	ice of Dea	ath (Chack	1 Yes				s 2 🗌	No	
ysicia is cert direct	To B	examiner?	No	Hospita	l: 1 🗌 Inpat	ient 2 🗆	ER/Outpatie	ent 3 🗆 DOA	Othe	r.	_	me 5 Resi	idence	6 🗆 Oth	er (Spec	cify)		
ading Ph tath. r: After thi	Certificate: 7	27. Manner of Death Natural 2 Accident	5 Pendir Investi	g gation	a. Date of inju (Month, Da	ıry	28b. Time of injury		c. Injury work?	at		28d. Describe						
ital or Atte		3 ☐ Suicide 4 ☐ Homicide	6 ∐ Could determ		. Place of Inj building, et			reet, factory,	office			28f. Location (City or To			er or Ru	ral Rout	te Number,	
the Hospi hin 24 hou the Funer	Medical	(Check 2 only one) 3	☐ Medical E ☐ Certifying	Nurse Pract	the basis of	examination	and/or inve	stigation, in m death occurre	y opinioned at the	n, death o time, date	ccurred at	d due to the ca the time, date e, and due to the	and pla he caus	ice, and du e(s) and m	e to the anner as	cause(s) stated.		er stated.
ov. T		29b. Signature and t	TITLE Of certifier	10		da		YO 29c.	License	number	47	3.	29d. I	Date signe	3 (Mont	, (201	
114		30. Name and addre	Jan	who complete	non	10.	1139	Print)	PAL	- C	T,	Hag	to V	Ho	un,	W	521	140
Stat Registra		31. Date filed (Mont)	90V O'4	2011	32. Registr	ar's Signa	D. A	NEW S					7					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death November 1, 2011 Physician/ 3:05 AM Emma R. Lesenana Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Bowie 13100 5th Street If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours **Director** 569-57-1262 1 □ M 2 🗶 F Yrs. Philippines May 28, 1933 78 Usual Residence of Deced or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10a. State Director 1X Yes 2 No Prince George's Bowie Maryland 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral USA 13100 5th Street 20715 within 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian. Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced If Yes, Give Year or Dates Completed Filipino 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4 or 5+) **5+** Elementary/Secondary (0-12) Ith and Mental Hygiene
27 is marked other the
traumatic event, the Teacher Education Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျှ Tarlenco Felisa Villanueva Hermgenes Reyes permit. Page 1 and 2 should be Department of Health and Ment Important. If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 410 Bell Ave #68 Sacromento, CA Nonatus Lesenana/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date Mount Park 1 Burial 2 Cremation 3 Removal from State Fair Oaks, CA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License ^{22. Name and Address of Facility} Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Hepatocellular Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter the arriving Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): physician sthe buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) the hed ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed | d be det þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? 1 Yes 2 X No has certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 Yes Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 2-X No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of injury (Month, Day, Year) n 24 hours after death.

e Funeral Director: After the pletely filled in by the funera 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 5 Pending iniury 1 X Natural 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

within 2.

State Registrar

NOV 0 2 2011

29b. Signature and title of certifie

ddress of person

Elizabeth Pfaffenroth 1221 Mercantile Lane Largo, MD 20774-5374

npleted cause of death (Item 23a) (Type, Print)

MD

29c. License number

D0068056

29d. Date signed (Month, Day, Year)

11/1/11

Specify: White 16b. Kind of Business/Industry Carpentry 18.Mother's Name (First, Middle, Maiden Surname) Pauline Violet Hollingsworth 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 20c. Location - City or Town, State Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A. MOO817 30195 three Notch Rd., Charlotte Hall, MD 20622 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Death the Hospital or Attending Physician: The law requires that the death certificate be executed hin 24 hours after death. Division of Vital Records, P.O. Box 68760, 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 V Unknown 24b. Were autopsy findings available prior to completion of cause of 2 No Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred Certification: 1 🗸 Natural 1 Yes 2 No To the Funeral Director: Pending filled in by the Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Ca 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. November 8, 2011 DOME 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner 900 W. Baltimore Street, Baltimore, MD 21223 32. Registrar's Signature State T'8201 arka Registrar

36985

1653 hrs

Country Washington

D.C.

10d. Inside City Limits

1 Yes 2 X No

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 11^{Month} Day 20^{Year}1 Linda Barbara Mallon Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Atlantic General Hospital Worcester Berlin 5. Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. . Age (In yrs. last birthday) Funeral 8. Date of Birth 1 M 2 DXF 5/16/1946 **Director** 099-36-7535 65 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County within 72 hours after death with the Maryland the Medical Examiner must be notified at Director 10c. City, Town or Location MD Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9715 Healthway Dr. 21811 USA "natural", or items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married 21215-0036 1 Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Accounting Be Maryland 17. Father's Name (First, Middle, Last) 085 is marked ည be Raymond Mallon Lillian Bentz 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Theresa Haight/friend Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 X Cremation 3 Removal from State 11/3/2011 4 Donation 5 Other (Specify) First State Crem. I Service License 23a. Part 1. Enter the disease, or complications that o used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause open line. Immediate Cause (Final 1 Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence A **Examiner** de 00 2 Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or ill nor y that initiated events Due to (or as a configuence of) that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Completed by Physician/Medical 68760 IF FEMALE 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 🔀 No
9 ☐ Unknown 23c. If yes, outcome of pregnancy Box (Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death 008 9 Unknown P.0. been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Attending Physician: The law requires Records, 1 🗌 Yes 24a. Was an s certificate has blirector, page 2 s autopsy performed?

28a. Date of injury (Month, Day, Year)

MD

NY Telephone Co. 18. Mother's Name (First, Middle, Maiden Sumame) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 315 Ivy Stone Dr., Greenville, SC 29615 20c. Location - City or Town, State Millsboro, 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 X No 26. Place of Death (Check only one) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred injury 1 Yes 2 🗌 No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d Date signed (Month Day Year) November 2, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9715 Healthway Dr. Berlin, MD 21811 Registrar's Signature ORIGINAL

36986

8:54 AM

9. Birthplace (State or Foreign

NY

10d. Inside City Limits 1 Tes 2 XNo

Country)

white

Registrar DHMH 17 Rev 7/2009

BA10

State

within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director,

2

Be

Certificate: To

Medical

Division of Vital

25. Was case referred to medical

William H.
Date filed (Month, Day, Year)

2 **X**No

5 \square Pending

Investigation

determined

Robins,

6 Could not be

NOV 0 3 2011

examiner?

29a. Certifier

(Check only one) 29b. Signature and title of certifie

27. Manner of Death

XNatural

Accident

Suicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle | ast) 2. Date of Death Physician/ October [Mary Myers 2011 2:55 AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester . Social Security Number 8. Date of Birth (Month, Day, 9/28/1 7. Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1 🗆 M 2 🔀 F 149-26-2332 **Director** 78 93 Usual Residence of Decedent show 10a. State 10b. County with the Maryland ms 23a or 28a-f sho must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Palm Beach Palm Beach Shores 10e. Street and Number 10g, Citizen of What Country? items 23a Funeral 26 Lake Dr USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Examiner 14. Race - American Indian. Black, White, etc. 9 2 1 Never Married 2 X Married 1 Yes 2X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify: "natural", Completed 3 Divorced 4 Divorced white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Department of Health and Mental Hygiene. Important, If item 27 is marked other than ' any injury or other traumatic event, the Me Eastern Shore Elementary/Seconday (0-12) College (1-4 or 5+) Secretary Seafood Products Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ permit. Page 1 and 2 should be 1 Ellis Brown Margaret Inman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) husband Arthur R. Myers, Jr. 26 Lake Dr., Palm Beach Shores, FL 33404 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Atlantic View Cem 11/3/2011 Manasquan, NJ 21. Signature of Funeral Service Lig 22. Name and Address of Facility Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Failure to thrive Medical resulting in death) Examiner End Stage Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

To the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the should be detached 24 hours after death. Funeral Director: After this certificate has

Myers,

Completed by 24a. Was an performe Yes 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital Other: ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify 27, Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) X Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. 3 X certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signatur

29c. License number 29d. Date signed (Month, Day, Year) R 135131 October 31, 2011

1 ☐ Yes 2 ☐ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pennie Savage, CRNP, 9715 <u>Healthway Dr, Berlin, MD</u> 21811 31. Date filed (Monthy Bay, Year)

State Registrar

NUA U

Hospital or Attending Physician: 24 hours a

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

29c. License number O.C.M.E.

900 W. Baltimore Street, Baltimore, MD 21223

29d. Date signed (Month, Day, Year)

November 3, 2011

and manner stated

Assistant Medical Examiner

32. Registrar's Signature buscan

Ocossel 30. Name and address of person who completed cause of death (Item 23a)

29b. Signature and title of certifie

Melissa Brassell, MD

OCME

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			1 _ State	State of Maryland	d / Department of I <i>Certificate of</i>			0011	36989
			Registrar 1. Decedent's Name (First, Middle, Last)		- Cortinoate or	Douth	2. Date of Death	2011	3. Time of Death
**	Physici /Medic		Genevieve Cor	rine Mill.	S		11 0"		
	Examir	er	4a. Facility Name (If not institution, give s	A A		Sprine		County of Death	
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. la	ast birthday) If Under 1 Year	If Under 24 Hrs.	8 Date of Birth	9 Birth	place (State or Foreign
	Director		220 20 021.	M 2∏ F 89	Yrs. Months Days	Hours Min.	(Month, Day, Yea 6-17-19	22 M	Intry)
	ow et		Usual Residence of Decedent 10a. State 10b. County		, Town or Location				10d. Inside City Limits
	a-f sh	ctor	MD Washing	ton	ear Spring				1 □Yes ¾ □No
	th with the 23a or 28 ast be no	Funeral Director	10e. Street and Number 11746 Hanging	Rock Rd.	10f. Zip Code 217	722	10g. (U	Citizen of What Cou.S.A.	untry?
Maryland 21215-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marke event, if a fractical Examination or continual to market and the continual to the fraction of the continual to the fraction of the continual to the fraction of the continual to the fraction of the continual to the c	þ	11. Marital Status 1 □ Never Married 2 □ Married 3 ▼ Widowed 4 □ Divorced	2. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Ye ar or Dates:	5. 13. Was Decedent of Hif Yes, specify Cub 1 □ Yes 2 ▼ No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White Specify: Wh	
2-0	72 ho "natur	eted	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Decedent's Usual Occup (Give kind of work done	during most of wor	kina	Kind of Business/li	
121	within iene. than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retire. homemakei	,		residen	ce
		BeC	5th grade 17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle, Maid		
<u> Yaa</u>	should be tnd Mental s marked umatic ev	2	Earl Richard R			Anna			
Mar	nd 2 sh Ith and 27 is n traum		19a. Informant's Name/Relationship (Type Fay E. Reed	_{daughter}	19b. Mailing Address (Street 12323 Funkt				
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic et once.		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ R	20b. Pli	L ace of Disposition (Name of imetery, crematory or other pla irsValley Ce	ce) 11 (Date 20c.	Location - City or T	own, State
altır	mit. Partme		4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio n e		22. Name and Addre	ess of Facility		_	
ñ	Per Deg		Vaniel o far	iley It CKSP	Donald I	Edwin Th	nompson F	uneral g. MD 2	Home,Inc 1722
			23a. Part 1. Enter the disease, or complications, or heart failure. List only on	cations that caused the death. e cause on each line.			or respiratory arrest,	3,	Approximate Interval Between Onset and Death
F	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Respiration		re			
	Examiner		b	F5chem	ic Stroke	2			15 months
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a conseque				İ	
	execul n and al-tran	Examiner	thet initiated events resulting in death) Last	Due to (or as e conseque	ence of):	··			
58750,	ifficate be executed g physician and as the burial-transit	edical	d						
ב ב ב	ertifica ding ph e as th	Med	IF FEMALE:						
O. Box	To the Hospital or Attending Physician: The law requires that the death certific thin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	hysician/M	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of de 9 ☐ Unknown	death 3 Ectopic pregnand	ey		23d. Date of deli Month	very Day Ye ar
Τ,	s that I	by Ph	Part II. Other significant conditions con	tributing to death but not resul	ting in the underlying cause giv	en in Part I.	23e. Did tobacc	o use contribute to	the cause of death?
cords,	equire sen sig ould b						1 ☐ Yes	2 No 3 □ Pro	obably 4 🗌 Unknown
É	e law r has be e 2 sh	Completed					24a. Was an autopsy	prior to c	topsy findings available completion of cause of
VITAI H	n; The ficate r, pag		05 W				performed 1 □ Yes 2 □	death? No 1 ☐ Yes	2 □ No
= :	ysicia is certi directo	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Innatient 2 F	ER/Outpatient 3 ☐ DOA Oth	or.	th (Check only one) ome 5 Residence	6 □Other (Spec	~
0 2	ng Phy fter thi neral (n:T	27. Manner of Death 1 Natural 5 □ Pending		28b. Time of linjury 28c. Injury Wor		28d. Describe how in		aiy)
VISION	ttendii Jeath. tor: A the fu	catio	2 Accident investigation 3 Suicide 6 Could not be		M 1□	Yes 2 □ No			
	al or Al after d Direct d in by	Certification:	4 Homicide determined	28e. Place of Injury - At hon building, etc. (Specify)	ne, farm, street, factory, office		28f. Location (Street City or Town, Sta	and Number or Ru ate)	ral Route Number,
1	e Hospita 124 hours e Funera letely fille	edical C	29a. Certifier (Check only one) Certifying Phys	ician: To the best of my know er: On the basis of examinati and manner stated.	vledge, death occurred at the ti ion and/or investigation, in my o	me, date and place opinion, death occu	a, and due to the cause arred at the time, date a	e(s) and manner as and place, and due	stated. to the cause(s)
4	Vithin To the comp	Me	29b. Signature and title of certifier		29c. Licens		1	Date signed (Month	n, Day, Year)
	,			2100	23a) (Type, Print) W. High ST	0662'	15 1	1/7/20	011
1	W-4		30. Name and address of person who cor	mpleted cause of death (Item	23a) (Type, Print)	+ Hai	ncock r	nd a	21750
A	Stat	0	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ire Jin 3	, ,,-01			-, ,,,,

Registrar

State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death November 4 Physician/ 20Î1 Charles Donald MacDonald 9:00 A M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 103 Southern Oak Drive Washington Hagerstown Social Security Number 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Sex 1X M 2 □ F Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Aug. 6, 1931 Months Hours 577-40-4325 Washington, D.C. Director 80 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 103 Southern Oak Drive USA 12. Was Decedent Ever in U.S.
Armed Forces?

1X Yes 2 Nol 1952—
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2XX Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Completed 3 Widowed 4 Divorced 1954 White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Car Sales Salesman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles S. MacDOnald Mary Catherine Rockwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Peggy H. MacDonald - Wife 103 Southern Oak Drive Hagerstown, Maryland 21740 20a. Method of Disposition

1

Burial

Cremation 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Hagerstown Crematory Nov.7,2011 Hagerstown, Maryland 4 Donation 5 Osbonane Afrancia lty Home, P.A. 21. Signature of Fu 425 S. Conococheague St.Williamsport, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ Medical resulting in death) Examiner cotonary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exarmine Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be execute the burial-tran Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Chronic Kidney disease Hyperlipideaia Division of Vital Records. Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical completed filled in by the funeral director. To Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **N**0 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: 28b. Time of 1 Natural 5 Pending 1 Yes 2 🗆 No 2 ☐ Accident 3 ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Hospital Medical 1 Secretifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier May Ellower DZ3815 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TW 5+1 Moure WID 8 354 31. Date filed (Mor State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death To bes Physician/ 43 P. M 201 Rupert Emmitt Mobbs Medical a. Facility Name (if not institution, give street and number **Examiner** ation of Death County of Death Social Security Number 8. Date of Birth (Month, Day,) February If Under 24 Hrs 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Months Days Loughry) I Arkansas Hours Min. Yrs. Director 432-20-2533 Usual Residence of Deceden or 28a-f shov event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1XX Yes 2 No <u>Maryland|Charles</u> Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 3924 Old Washington Road 20602 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No Air If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ō þ 1 Never Married 2 Married Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2XX No Specify. White "natural", Completed 3 X Widowed 4 Divorced Specify 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Heath and Mental Hygiene. Ilmportant If item 27 is marked other than any injury or other trainmain. Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Wilford Mobbs Pearl Estelle Spears 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elton Mobbs/ Son 3924 Old Washington Rd. Waldorf, MD. Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Green Briar Arkansas Thorn Cemetery 4 Donation 5 Other (Specify) November 1, 2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Huntt Funeral Home Mougo 3035 Old Washington Rd. Waldorf, MD 20601 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cycle on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ KR disease or condition Medical resulting in death) Examiner ANCINEA MON Sequentially list conditions, if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day 2 No signed by the a 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown cate has been signated by page 2 should b 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospita Other: မ ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Date of injury (Month, Day, Year) Certificate: 28a 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 2 🗆 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check only or Certifying Nurse Practioner: To the best of my knowledge, de ath occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatu nd title of certifie 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month_Day

of death (Item 23a) (Type, Rrint)

32. Registrar's Signature

1-08396		Please Type or Print in Black Indelib			gible.	
elestina Gay N		crate or many tarrar population.	nt of Health and Mental		2011	3699
Physici		Registrar 1. Decedent's Name (First, Middle,Last)	- COLDOGUI	2. Date of Deat	h 3	. Time of Death
Medical Exam	iner	Celestina Gay Martinez		Month November		0135 hrs
1		4a. Facility Name (if not institution, give street and number) 4915 Monroe Street #2	4b. City, Town, or Location of De- Bladnesburg Blade		4c. County of Death Prince George's	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	ay) If Under 1 Year If Under 24h	Irs. 8. Date of Birt	th(MM/DD/YYYY) 9. Birthp	lace (State or
Director		217-72-2829 _{1□M 2▼F} 53	Yrs. Months Days Hours N	October	28, 1958 Foreign Count	_{try)} Maryland
y		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	location		11	Od. Inside City Limits
j tow any		Maryland Montgomery Silver S				Yes 2 X No
Maryland 28a-f show 1 at once.	Director	10e. Street and Number	10f. Zip Code	10	ng. Citizen of What Country	y?
15-0036 filed within 72 hours after death with the Maryland Hyggene. ed other than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.		14213 Georgia Avenue	20906		USA	
th with ems 23	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue		14. Race - America White, etc.	n Indian, Black,
- 5 B		1 Yes 2 X No	1 X Yes 2 No specify: S	panish	Specify: Whi	te
ours afi ntural'	d by	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	cedent's Usual Occupation (Give kind or ing most of working life, DO NOT use in	of work done	16b. Kind of Business/Ind	ustry
16 n 72 h nan "m ical Es	olete	Elementary/Secondary (0-12) College (1-4 or 5+)	aitress	etiled)	Restauran	t
21215-0036 21215-0036 suld be filed within 7 Mental Hygiene. marked other than e event, the Medica	Completed	10 W6		me (First, Middle, N	Maiden Surname)	
215 be filed ntal Hy rked o	Be C	Feliberto Celestino Martinez	Juanita	a Clay Re	ese	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	7		Mailing Address (Street and Number of Bay Avenue, Unit 20			
mand 2 sho lealth and tem 27 is		20a. Method of Disposition 20b. Place of D	Disposition (Name of cemetery,	Date	20c. Location - City or Yo	
Baltimore, permit. Pages 1 as Department of He Important: If ite		Metropol	or other place) itan Crematory 11	/11/2011	Alexandria	, Virginia
altin mit. P partme portao		4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	22. Name and Address of Facility		4739 Baltimo	re Avenue
	3		Gasch's Funeral H	ome, P.A.	Hyattsville,	MD 20781 Approximate Interval
Physician /Medical		23a. Part I. Enter the disease, or complications that caused the death. Do not e failure. List only one cause on each line.			est, snock, or neart	Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Narcotic (Morphine) Due to (or as a consequence of):	and Cocaine Intox	cation		
	L	Sequentially list conditions, b				
	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
ed nsit	Examiner	events resulting in death) Last Due to (or as a consequence of):				
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Eg.	X UNPENDED X AMENDED 23a, 27, 28a-1	.per me,g921 11-2	1-11 sm		
760, cate be physici he buri	Med	4D, per me, g922 12- IF FEMALE: 23c. If yes, outcome of pregnancy	-5-11 sm		23d. Date of delivery	
Box 68760, e death certificate be the attending physic ed for use as the bur	cian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Live birth 5 Pregnant at time of death 5	Fetal death 3 Ectopic pred Other (Specify)	gnancy	Month Da	y Year
Box e death the atte	Physician/Medi	1 Yes 2 No 9 V Unknown 9 Unknown		****		
, P.O. ires that the signed by	by P	Part II. Other significant conditions contributing to death out not resulting in	the underlying cause given in Part I.		bacco use contribute to the	
ds, F equires een sign				– 24a. Was a	an 24b. Were auto	psy findings available
COLO law re has be	Completed				med? death?	mpletion of cause of
tal Rec		25. Was case referred to medical	26.Place of Death (Che	1 ✓ Yes : ck only one)	2 No 1 Yes	2 No
this yai	o Be	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	atient 3 DOA Other Nu	rsing Home 5	Residence 6 🗸 Other: \$	Scene
ing Pt After funeral	n: T	1 Notural (Month, Day, Year)	ne of Injury 28c. Injury at Work?	28d. Describe I	now injury occurred	
Sior Attend r death ector: by the	cati	Accident Pending Investigation Fd 11-9-11 Fd 1	:U3 pm	28f. Location (\$	Street and Number or Rura	I Route Number, City
Divi	Certification:	Suicide 4 Homicide 6 X Could not be determined (Specify) Apart		or Town, S Bladens	tate) 4915 Monro burg, Md.	e St. #2
Division To the Hospital or Attent within 24 hours after death To the Fuoeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death	occurred at the time, date and place, a	and due to the caus	e(s) and manner as stated	
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or inversand manner stated. 29b. Signature and title of certifier	estigation, in my opinion, death occurre	at the time, date	and place, and due to the	
	2	All ly has all the second	O.C.M.E.		November 9, 2011	
)		30. Name and address of person who completed cause of death (Item 23a)				
		Melissa Brassell, MD Assistant Medical Examiner 90		more, MD 2122	23	
S Regis	tate	31. Date filed (Month, Day Year) 32. Registrar Signature 1. Signature	1			

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 36993 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Physician/ Month Sara B. Orpin Oct_ 6:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Buckingham Choice Frederick Adamstown 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** 1 M 2 XX Days Hours Min. Sept 5, Months Yrs Alabama Director 421 12 0143 Usual Residence of Decedent 28a-f shov within 72 hours after death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 🗆 Yes 2 🔽 No Maryland 1 4 1 Frederick Adamstown 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? Examiner must be items 23a Funeral 3200 Baker Circle United States 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. ŏ þ 1 Yes 2 X No If Yes, Give Year or Dates. 1 Never Married 2 Married Maryland 21215-0036 1 Tes 2 V No Specify: "natural", Specify: 3 K Widowed 4 Divorced White Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) filed within tal Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) Operator Southern Railway Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ith and Mental H 27 is marked of traumatic ever ပ Page 1 and 2 should be ment of Health and Menta Robert Luther Blackwell Mattie Brooks 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Victoria A Orpin (daughter) 4324 Buckeystown Pike, Frederick, MD 21704 Baltimore, 20a. Method of Disposition
1 ♣Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Resurrection Cemetery Nov 4, 2011 Clinton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Signature of Funeral Service Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Athersclerotic Vascular Disease Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death signed by the a d be detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ី Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? Was an has autopsy performed Yes 2 after death.

Director: After this certificate I 2 No completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 X Other Specify 2 X No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of injury Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined To the Hospital o within 24 hours at To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d. Date signed (Month, Day, Year) Oct 31, 2011 D0058726 30. Name at ddress of person who completed cause of death (Item 23a) (Type, Print) Yvette Warren, M.D. 3000- D Ventric Court, Myersville, MD 21773 31. Date filed (Month, Day) 32. Registrar's Signatu State 2 2011

Registrar DHMH 17 Rev 7/2009 rock

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 = For Amend 9 & 20b State of Maryland / Registrater FD, DOR, 11/4/11, LDB	Department of Health and I Certificate of Death		ene g. No. 2011	36994
Physici	an/	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physici Medi	cal		LLIPS SR	1.	01 2011	17:32 M
Exami	ner	4a. Facility Name (if not institution, give street and number) 2428 HOOPERS ISLAND ROAL	4b. City, Town, or Location of Death FISHING CR	EEK	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last bir			9. Birt	hplace (State or Foreign
Director		2/5-26-599/ 1 ØM 2 □ F Usual Residence of Decedent	Yrs.		1930 Do.	1110.
e Maryland r 28a-f shov notified at	tor	10a. State 10b. County 10c. City, Tow				10d. Inside City Limits
or 28a	Director	MD Dorchester Fi	shing CReek	10	g. Citizen of What Co	1 Ves 2 No
With the state of	Funeral	2428 Hoopers Island A	21. 21634	10	LLJA	uriti y ?
death ritems		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
21215-0036 within 72 hours after giene. er than "natural", or the Medical Exami	ed by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Year or Dates.	1 ☐ Yes 2 💆 No Specify:		Specify:	hite
15-0	Completed	15. Decedent's Education (Specify only highest grade completed)	Decedent's Usual Occupation (Give kind of work done during most of work	king 16	6b. Kind of Business/	ndustry
212-	Con	Elementary/Secondary (0-12) College (1-4 or 5+)	life DO NOT use retired) eputy Sherifi	- /	aw Enfo	reement
	To Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Ma		
Maryland 2 should be filed th and Mental Hy 27 is marked out traumatic event	۴	HRThur Willie Phillips 19a. Informant's Name/Relationship (Type, Print) 19a			Ida Ph	
		l'activité de l'institute de l'insti	o. Mailing Address (Street and Number or Run 2455 An Lieus			
altimore, I rmit. Page 1 and : partment of Heali portant: If item 2 y injury or other ce.		20a. Method of Disposition 20b. Place of	of Disposition (Name of		0c. Location - City or	
Baltimo permit. Page Department of Important: If any injury or once.			hester Memorial 41	4/3011	LAMBI 308 Hisk	
Depril		Roulous Collins	22. Name and Address of Facility Curran Av - Brance		cambrid	ge, mo
		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.				Approximate Interval Between
—Physician/ Medical		Immediate Cause (Final disease or condition resulting in death) a. CHRONIC K Due to (or as a consequence	IDNEY FAILURE			Onset and Death 2 YEARS
Examiner		DIABETES	MELLITUS			LO YEARS
o ti	Examiner	if any, leading to immediate cause. Enter Underlying	of):			
executed an and rial-trans		Cause (Disease or injury that initiated events resulting in death) Last C. Due to (or as a consequence				10 YEARS
bu bu	dical	d		<u>.</u>		
687 sertifica iding pl	ıω	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			22d Data of dal	
Box 6876(death certificate he attending physeled for use as the	Physician/M	in the past 12 months? 1 Ves 2 No 1 Ves 2 No	h 3 Ectopic pregnancy 5 Other (specify)		23d. Date of del Month	Day Year
that the coned by the edetache	Phys	9 Unknown Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I	220 Did toba	cco use contribute to	the cause of death?
S, F	d by	HEART FAILURE	and and any my states given in real in			obably 4 Munknown
VITAI KECOTGS, ysician: The law requires is certificate has been sig director, page 2 should b	Completed			24a. Was an autopsy	24b. Were aut	opsy findings available completion of cause of
He la cate ha page				performe 1 Yes 2	ed? death?	2 🗆 No
/Ital	To Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/O	26. Place of Death (Chec		ce 6 Other (Speci	6.1
OT ng Phy fter this		27. Manner of Death 28a. Date of injury 28b.	with the second	28d. Describe how		ry)
SION ttendi death. stor: Ay y the fu	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 XNo	0011 - 11 - 01		- Device Number
DIVISION OT tall or Attending Pt is after death. In Director: After the ed in by the funeral		4 Homicide determined 286. Place of Injury - At nome, is building, etc. (Specify)	im, street, factory, office	City or Town, S	et and Number or Rur State)	ai Houte Number,
DIVISION OF VITAL RECORDS, P.O. BOX 687 To the Hospital or Attending Physician: The law requires that the death certifics within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier 1 Certifying Physician: To the best of my knowledge, (Check 2 Medical Examiner: On the basis of examination and/	or investigation, in my opinion, death occurred a	it the time, date and	place, and due to the o	ause(s) and manner stated.
Fo the within 2 Fo the Spmple	M	only one) 3 Certifying Nurse Practitioner: To the best of my kno 29b. Signature and title of certifier	wledge, death occurred at the time, date and pl 29c. License number		cause(s) and manner as d. Date signed (Month	
3		Kuffan	00070757	2 ~	10V 03	2011
		30. Name and address of person who completed cause of death (Item 23a) Rohan W. Moffatt, M.D., 503 Byrn		D 21613		
Sta		31. Date filed (Month, Day, Year) 3. Registrar's Signature	bar			
Registr	ar 🍦	NOV 0 & 2011 Sepur A.,	CONTRACTOR OF THE PARTY OF THE			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 36995 Certificate of Death Decedent's Name (First_Middle_Last) 2. Date of Death Physician/ ERCÉ Month /O 0000 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospice Harwood Mandrin Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Funeral 559- 58 - 1801 Director 1 M 2 D F 69 Sept. 2,1942 Indiana Usual Residence of Decedent 28a-f shov 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director Prince George's Upper Marlboro Maryland 1 🗆 Yes 2 😿 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral U.S.A. 9525 Sherwood Drive 20772 or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14 Race - American Indian. 1 V Yes $2 \square$ No 1959-Black, White, etc. þ 1 Never Married 2 XXMarried within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XXNo and Mental Hygiene.

is marked other than "natural", Specify: 3 - Widowed 4 - Divorced White Completed 1963 Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Accounting Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ೭ Vance Helen Μ. Edwin F. Pierce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. 9525 Sherwood Drive, Upper Marlboro, MD 20772 Pierce - Wife Bernadette 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Nov. 8,2011 Clinton, Maryland Lee Crematory 4 Donation 5 Other (Specify) 21. Signature of Funer Se 22. Name and Address of Facility Lee Funeral Home Calvert, P.A. Amanda M. Ergler 8200 Jennifer Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PARKINS Physician/ ON disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last use as the burial-tran Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Month Day Year the the 2 No been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be MANDRING ther (Specify) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours after death. Funeral Director: After this 27. Manner of Death House 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1_Natural 5 Pending work? 2 No Accident Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a Certifier completely (Check To the within 2 3 Certifying Nurse Practitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of contifie o completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 06-2011

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State

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Name and address of persons

31. Date filed (Month, Day

ENTA

32. Registra s Signature

NNAPOLIS MDZIYOI

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - State of Maryland / Dep	artment of Health and I	Mental Hygie	701	36996
Dhusisis	- /	1. Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death
Physicia Medic		JOHN WELTON PROCTOR			29, 2011	11:49 A M
Examin	er	4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Deat	
Funeral	-	9523 Temple Hill Rd. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Clinton If Under 1 Year If Under 24 Hrs.	8, Date of Birth	Prince G	hplace (State or Foreign
Director		578-20-1553 1X M 2 □ F 90 Yrs.	Months Days Hours Min.	Jan. 18,	1921 Mar	y Iand
d w	L	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	agation			10d. Inside City Limits
arylan a-f sh fied a	Director	Maryland Prince Georges Clinton	Cation			1 ☐ Yes 2 XXNo
he Ma or 28,		10e. Street and Number	10f. Zip Code	10g	. Citizen of What Co	
with to	Funeral	9523 Temple Hill Rd.	20735	U	.S.A	-
death items	Fun		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - Ame	
after of I", or kamir	l by	1 Never Married 2 Married 1 Ves 2 No	1 ☐ Yes 2XXNo Specify:	Triburi, o.o.,	Black, White Specify: Bla	
within 72 hours after death with the Maryland giene. than "natural", or items 28a or 28a-f sho, the Medical Examiner must be notified at	Completed	Year or Dates. Year or Dates.	dent's Usual Occupation	16	b. Kind of Business	
n 72 h an "n Medi	dm	(Specify only highest grade completed) (Give	kind of work done during most of wor OO NOT use retired)	king	b. King of Egainess	madstry
withii giene ger th		12 Labo:	rer	C	onstructi	on
c, INCL STATE TELL TELL TELL TELL TELL TELL TELL	To Be	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maid	den Surname)	
maric		John Alexander Proctor		Proctor		0.11
2 should be shou		1	ing Address (Street and Number or Rui $01d$ Alexandria Fe			1
1 and 1 and of Hea item othe		20a. Method of Disposition 20b. Place of Disp	osition (Name of		c. Location - City or	
Page ant: If ury or			matory or other place) ans Cemetery Nov.	.8, 2011 C	heltenham	, MD
permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Department of Health and Mental Hygiene are stated on the than "natural", or items 28a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.			2. Name and Address of Facility			
1 20 E 8 0			033 Old Alexandria		. Clinton	
		23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
Physician/ Medical		disease or condition resulting in death) CONGESTIVE HEART Due to (or as a consequence of):	FAILURE			Onsor and Doda
Examiner		ATHEROSCLEROTIC	CARDIOVASCULAR DIS	SEASE		
	iner	Sequentially list conditions, if any, leading to immediate ause. Enter Underlying Due to (or as a consequence of):				
scuted and transi	Examiner	Cause (Disease or iinjury that initiated events c				
be executed sician and burial-transit	dical E	resulting in death) Last Due to (or as a consequence of):				
icate l	ledic	d				
ath certifica attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal death 3	Ectopic pregnancy		23d. Date of de	livery
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requires that the de been signed by the should be detached	Completed by	DIABETES MELLITUS TYPE 11	, , ,			robably 4 🛣 Unknown
requiper should	lete	ESSENTIAL HYPERTENSION		24a. Was an		topsy findings available
The law ate has page 2:	omb	DEMENTIA		autopsy performed	d? death?	completion of cause of
ian: T	BeC	25. Was case referred to medical	26. Place of Death (Chec	1		
hysic his ce	P	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient		lome 5 Residenc	e 6 Other (Spec	sify)
ding P h. After t funerz	Certificate:	27. Manner of Death 1 XNatural 5 Pending 28a. Date of injury (Month, Day, Year) injury	of 28c. Injury at work? M 1 □ Yes 2 □ No	28d. Describe how i	injury occurred	
Atten r deat ector: by the	ij	2		28f. Location (Stree	t and Number or Ru	ral Route Number,
tal or safte		building, etc. (Specify)		City or Town, S	itate)	
Hospi 4 hour Funera ted fills	Medical	29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death (Check 2 Medical Examiner: On the basis of examination and/or inve				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death and after death certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi	ž	only one) 3 Certifying Nurse Practioner: To the best of my knowledge 29b. Signature and title of certifier		ace, and due to the cau		stated.
F S F Ö		* Lacombleooe	MD# 33255		TOBER 31,	
1770		30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)			
U		KAREN ANN BLACKSTONE, M.D. VAMC, 50	IRVING STREET NW,	WASHINGT	ON,DC 204	22/688
Stat Registra		31. Date filed (Month, Day, Year) NOV 0 2 2011 32. Registrar's Signature	barker			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ October 31, 2011 2:15 Leola Evelyn Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Center LaP1ata Charles Charles <u>Civista Medical</u> 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) MA 1 □ M 2 😾 F Months Days Hours March 13, 016-30-7740 74 **Director** Usual Residence of Decedent 28a-f shov 10a. State notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits rector 1 ☐ Yes 2 🛣 No La Plata Charles ۵ 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? must be 23a Funeral 7680 Lakes End Court 20646 USA items within 72 hours after death 12. Was Decedent Ever in U.S. Was Deceue... Armed Forces? Ves 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, the Medical Examiner Black, White, etc. ò δ 1 Never Married 2 Married 1 ☐ Yes 2 If Yes, Give Year or Dates Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: "natural", 3 X Widowed 4 Divorced White Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker e 1 and 2 should be filed wit of Health and Mental Hygie If item 27 is marked other or other traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ronald Tiffany Evelyn May Fowler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once. Andrew Pike/Son 7680 Lakes End Court, La Plata,MD Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State Brinsfield-Echols Crem. 11/2/2011 Charlotte Hall,MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Eugeral Service Licen 22. Name and Address of Facility Arehart-Echols Funeral Home, PA M01458 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician Parkinson's disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami or Attending Physician; The law requires that the death certificate be executed physician and s the burial-transit 10 Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown ed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page perform 2 🗆 No 1 🗌 Yes Yes 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) No Other 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 27. Manner of Death
Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0062287 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3450 Old Washington Road, Suite 103, Waldorf, MD 20602 Betty Siu, M.D.

State

Registrar

31. Date filed (Month, Day, Year)

NOV 02

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Monther 9:06 P. M geraldine Medical Facility Name (if not institution, give street and number) ocation of Death nty of Death Examiner City, Tow If Under 24 Hrs 9. Birthplace (State of Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 ☐ M 2 💢 F Months Days Hours Min **Director** Yrs. Usual Residence of Decedent 28a-f shov 10b. County the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10f. Zip Code items 23a or Street and Number 10g. Citizen of What Country? Funeral 23308 20608 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Black. White, etc. ŏ þ 1 Never Married 2 Married Yes 2 No If Yes, Give Year or Dates 1 Yes 2 No Specify: and Mental Hygiene. is marked other than "natural", Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DONOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) tssuc Ate injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) မ Department of Health and Ment.
Important: If item 27 is marked any injury or other. 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HAWKIN 20668 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 3 21. Signature of Funeral Service Licensee 22. Name and Address of 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Fulu Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? ate has been signed by the atte page 2 should be detached for Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Tunknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No Yes Hospital or Attending Physician: director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes Other: မ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred **™**Natural 5 Pending 1 🗆 Yes 2 🗌 No Accident Investigation Could not be within 24 hours after deal To the Funeral Director: Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier сотретер (Check Certifying Ne my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tle of cer 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print) 30. Name and address of

State

Charlene Le 31. Date filed (Month, Day, Year)

NOV 0

32, Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State State Amend#4a,10e,19b,Per Funeral Home, Cettificate. Of Maryland / Department of Fleath 36999 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Charles Hubert Posey October 30, 201^r1^{ar} 9:40 a M Medical 4a. Facilie Rui 108 not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charles 2 Mekins Ave. Indian Head 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthdav) 9 Birthplace (State or Foreign 8. Date of Birth **Funeral** Sept. 13 1 XM 2 □ F 220-16-8287 Maryland 1926 Director 85 Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examiner must be notified at Director Charles Indian Head 1 X Yes 2 □ No Maryland 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or Funeral 20640 U.S.A. 2 Mekins Ave. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1944-1 ☐ Yes 2 ☐ No Specify "natural", Specify: White 3 Widowed 4 Divorced Completed 1946 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ad w... al Hygiene. "er than " Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene, Important: If item 27 is marked other that any injury or other traumatic event, the None. Self Employed Truck Driver Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elsie V. Milstead Charles Posey 19a. Informant's Name/Relationship (Type, Print) 19b. MMRR kanss (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Mekins Ave., Indian Head, Md. 20640 Wife Margaret V. Posey 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 2011 20c. Location - City or Town, State 1 💢 Burial 2 🗆 Cremation 3 🗀 Removal from State Waldorf, Maryland Trinity Memorial Gardens Donation 5 Other (Specify) Signature of Fune Williams Funeral Home, P.A. M00668 4270 Hawthorne Rd., Indian Head, Md. 20640 23a. Part 1. Enter the disease, or complications that caused shock, or head failure. List only one cause on each line ease, or complications that caused the death. Do not enter the mode of dying Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a 1 ☐ Yes 2 ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page perforn death? 2 🗌 No Yes 25. Was case referred to medical eral Director: After this certific filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital Other: 1 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5X Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) ë 28b. Time of Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Certifica 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) within 24 hours a

To the Funeral D Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 23a) (Type, Print)

State Registrar 32. Registrar's Signature

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			For State Registrar				,		tificat					Reg. N	- 2 E)	37000
	Physicia	an/	1. Decedent's Nam	e (First, Middl	e, Last)	ROBERT	T AN	DREW	PFE	FFER	KORN		2. Date of D	eath	ay	Voor	3. Time of Death
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	Examir	ner	4a. Facility Name (ii Carroll I	Ospice	e Dove Ho	use			4b. City		Location			4	c. County	of Death	4
	Funeral Director		5. Social Security N	7340_	6. Sex 1 M 2 D	7. Age ((In yrs. last i	birthday) Yrs.	If Unde Months	Days	If Under Hours	24 Hrs. Min.	8. Date of Bi Jan 1	rth ay, Year)	939		hplace (State or Foreign untry) NJ
	land show d at] =	Usual Residence of 10a. State	Decedent 10b. County	,		10c. City, To	own or Lo	cation						· <u>-</u>		10d. Inside City Limits
	/laryla 8a-f s tified	ect	MD	Car	roll		El	lders	bura								1 Yes 2 No
	a or 2 be no		10e. Street and Nur	nber						p Code				10g. C	itizen of	What Co	untry?
	th with ms 23 must	Funeral Director		Stillwa	ter Ct.						21784				USA		
9	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoath injury or other traumatic event, the Medical Examiner must be notified at once.	by Fu	11. Marital Status 1 ☐ Never Marr	ied 2 🔀 Mai	rried 1XXY∈	Forces?	ຸ 196	<i>-</i>					ecify Yes or No Rican, etc.)	-		e - Amer ck, White	rican Indian, e, etc.
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			23a. Part 1. Enter t shock, or hear Immediate Cause (t failure.List	r complications that only one cause on	t caused the each line.	he death. D	o not ente	r the mod	le of dying	g, such as	cardiac c	r respiratory a	rrest,			Approximate Interval Between Onset and Death
www.	Physician/ Medical		disease or condition resulting in death)		a. Due t	o (or as a c	negularo	elle 2001:	w							_	Oligot and Board
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P.O.	that the deaned by the a	by Pt	Part II. Other signif	cant condition	ons contributing to	death but	not resultin	g in the u	nderlying	cause giv	en in Part	l.	23e. Did 1	tobacco	use cont	ribute to	the cause of death?
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Re	sician: The law certificate has t irector, page 2 s			_										ormed?		death? 1 🔲 Yes	2 No
ital	lysician; is certific director,	Be	25. Was case referre examiner? 1 ☐ Yes 2 Ø	d to medical	Hospital:					Othe	ace of Deat						
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Division	l or Att after de Directo	Certificate:	3 ☐ Suicide 4 ☐ Homicide	6 Could determ	ined 28e. Plac	ce of Injury ding, etc. (S	- At home, Specify)	farm, stre	et, factory	, office			28f. Location (City or To			er or Run	al Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Euneral Director. After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1	Certifying	Physician; To the	best of my	/ knowledge	e, death o	ccured at	the time,	date and p	place, and	d due to the ca	ause(s) a	ind mann	er as stat	ted. ause(s) and manner stated
	thin 2, the F the F mplet	_ r	only one) 3 29b. Signature and t	□ Certifying □	Nurse Practione	r: To the bes	st of my kno	wledge, d	eath occu	red at the	time, date	and place	e, and due to the	ne cause((s) and ma	anner as s	stated.
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	2+IVA		30. Name and addre	ss of person v	who completed car	use of deat	th (Item 23a) (Type, Pr		00	286	7 6	0		22	())	
			Robert	Fee	itas.	7115	VC	al	10/c	ury	Ct	, C'	lark.	SVI	Ne	M	D 21029
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